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ORIGINAL ARTICLES.

FIVE CASES OF VAGINAL HYSTERECTOMY FOR MALIGNANT DISEASE OF THE UTERUS.—ALL RECOVERED.*

W. F. McNUTT, M. D., M. R. C. S., Ed., etc., SAN FRANCISCO.

CASE I. Mrs. B., age 57, born in New York, had one child, 1851, no cancer history, menstruated at 17, ceased at 41. At age 53 commenced having slight uterine hemorrhages; consulted several physicians in regard to it, had taken medicine and had astringent injections, etc., with the effect of partially controlling the bleeding. When she consulted me first at my office she had slight hemorrhage, mixed with a thick, ropy albuminous looking discharge—found the uterus slightly enlarged, canal tortuous and irregular, and had difficulty in passing the sound; neck granular and bleeding easily; made applications with astringents, ordered lead and carbolic injections, advised rest. There being no improvement and considering the case cancerous, I called Dr. Beverly Cole in consultation, when we dilated the uterus with Hager dilators. There was discharge of at least half an ounce of white-of-egg-like fluid mixed with blood, the whole neck of the uterus was nodular and presented an epithelial-like softened appearance. The woman was losing weight, strength and color; there was no mistaking the diagnosis, viz., *epithelial cancer*.

Mrs. B., having consented to an operation, I determined to make a vaginal hysterectomy, and on November 27th, 1888, removed the uterus. The external parts were shaved and thoroughly cleaned by soap and carbolized water, the vagina was disinfected and the patient placed in the dorsal position. The uterus

was brought down by a strong vulsella and a small vertical incision was made through the anterior vaginal wall. An aneurism needle with a ligature was passed through the opening, and brought out through the wall three-fourths of an inch to the right; this section was tied and divided with scissors; this process was continued until the neck was enucleated; the connective cellular tissue was mostly broken up by the finger; the uterus was then easily brought further down, not turned over, and the broad ligaments secured *en masse* by a carbolized silk ligature. I then put long compression forceps on the ligaments between the ligature and uterus, and divided the broad ligaments close to the uterus up to its upper margin, and over this undivided upper fold of the ligament I placed a ligature and cut the uterus free. I then tied these last two ligatures together stretching the broad ligaments across the cavity and making a roof, as it were, to the vagina; the vagina was then packed with iodoform gauze; the forceps were taken off in forty-eight hours. She was kept four weeks in bed; and seventeen months after the operation she was as well as she ever was. At no time after the operation was there any marked rise in temperature.

Of the pathology of this case Prof. D. W. Montgomery says: "Mrs. B. had an extensive neoplasm of the cervix uteri, both simple and malignant. The simple new growth was a papilloma. Below the papilloma was a epithelioma infiltrating very extensively the connective tissue."

*Read before the California Medical Society.

CASE II. Mrs. P., aged 44, married at 20, two children, youngest 17 years old, had one miscarriage 13 years ago, no cancer history. This case was under the care of Dr. W. H. Davies, who had attended her for several months for uterine hemorrhage, using internal remedies, injections and several times having to tampon the vagina with cotton saturated with Monsel's solution.

Dr. Davies told her his efforts were only affording her temporary relief and more radical measures would have to be tried. I was called in consultation and found the patient exsanguine to an alarming degree; an epithelioma of the cervix was unmistakable; the slightest touch caused profuse bleeding, necessitating the tampon after our examination. We advised removal of the uterus, and after a few days' delay she consented to the operation. July 25th, 1889, the operation was made. I gave the patient ether, and, placing her in the lithotomy position, the epithelial fungoid bleeding mass was curetted off and the bleeding in a measure controlled by hot water before enucleation of the cervix was commenced. Drawing the uterus well down with a vulsella the enucleation was soon made, the adhesions separated, and the broad ligaments clamped with compression forceps (no ligatures used), uterus cut loose. The forceps were left on fifty hours. The only difficulty encountered in this operation was the exhausted and exsanguined condition of the patient before commencing the operation. During the latter part of the operation she was constantly plied with hypodermic injections of whiskey, which were necessary to keep up the heart's action.

The patient was in excellent health and spirits nine months after the operation, with the exception that she has a small vesico-vaginal fistula, which did not give any evidence of its presence until after the fourth week.

CASE III. *Hysterectomy (for cancer) and Ovariectomy—Double Operation.* Mrs. F., age 67, a thin, wiry, but apparently well nourished old lady came to Dr. R. M. Elliott, of this city, from Washington Territory, on June 24th, 1889, suffering from an offensive discharge from the uterus. She had borne a large family of healthy children, and never had any severe illness up to the present time.

While riding on a buckboard about five

months ago, the horses in leaping a ditch tipped her backwards, and she fell, striking on her sacrum. The injury caused her considerable pain at the time, but it gradually passed off leaving no noticeable trouble afterwards. A smooth, elastic, immovable, round tumor could be felt through the abdominal wall in the region of the ovary. There was a purulent vaginitis and an excoriation of the os uteri with a purulent bad smelling discharge from the os. There had been at no time either pain or hemorrhage. After cauterization by Dr. Elliott with nitrate of silver, (the solid stick), the excoriation healed in part, the discharge from the os in a great measure ceased, and she returned to the country much improved, but with a slight discharge from the vagina which still persisted, and for which an injection of sulphate of zinc and acetate of lead, each 20 grains, tincture of opium one drachm, and water to eight ounces, was prescribed.

After two weeks she wrote stating the offensive discharge had returned just as before. On coming back to the city again for treatment a much more serious state of affairs was found than at first. The discharge was as abundant as before instituting treatment, and a fungoid, easily bleeding mass was seen projecting from the os uteri.

Dr. Elliott called me in consultation and an operation was advised, the patient was sent to the Children's Hospital and the date of operation set for August 11th, 1889.

Because of the abdominal tumor, the exact nature of which could not be determined before the operation, it was decided to first open the abdomen, examine its contents, and then act *pro re nata*. After a careful toilet, the abdomen was opened in the median line, and an ovarian cyst about the size of a cocoanut was found united by extensive adhesions to all the surrounding viscera, especially to the intestines. The adhesions were carefully separated, principally by the finger nails. After much labor the tumor was set free from the intestines, it still being firmly adherent to the uterus. The cyst contents were then evacuated. The uterus was found much enlarged; being about the size it should be at the second month of gestation; it was soft and boggy to the touch; adherent to the

surrounding tissues, especially posteriorly, an abscess being found between the uterus and the rectum. I then decided to enucleate the neck of the uterus per vaginam and remove the uterus through the abdominal opening. In enucleating the neck and going up between the rectum and the uterus the aforementioned abscess was opened and a large quantity of foul smelling pus was evacuated. The os uteri was also opened up and a large quantity of pus came away from the uterine cavity. The pus being got rid of per vaginam, and the neck being thoroughly enucleated, the operative procedures were subsequently carried on through the abdominal opening, removing the entire womb, the cyst in connection with it, and the left Fallopian tube.

Despite the age of the patient, the length of the operation (lasting fully three hours) and the amount of disturbance caused by the breaking up of the very extensive adhesions and the separation of such large masses of tissue, the patient's temperature never went above 101° , and the only bad symptom was some meteorism occurring on the third day and gradually subsiding again. Very little blood was lost during the operation; a point of great importance in elderly persons in whom the blood-making functions are not active.

Dr. D. W. Montgomery's report on the pathology of the parts removed, appeared in the reports of the San Francisco Medical Society where the specimens were shown. He says that it was an epithelioma of the cervix uteri, the infiltrations involving pretty much the whole cervix.

CASE IV. Mrs. P., aged 32, married, had children, was under Dr. S. S. Stambaugh's care for several months for fever, pain and uterine hemorrhage. I examined her in consultation with Dr. Stambaugh August 27, 1889; the uterus was much enlarged and immovable, cervix nodulated and vascular with granulating bleeding surface; broad ligaments thickened. There was a bad smelling vaginal discharge. There was no doubt about the cancerous nature of the disease. Mrs. P. came from a very malarious locality, and had high fever every day, notwithstanding Dr. Stambaugh had treated her for malaria.

We informed Mrs. P. of the nature of her disease, and that nothing but an operation offered her any chance from a dis-

ease which must soon prove fatal. The enlargement and fixed condition of the uterus with the involvement of the broad ligaments made the prospect for an operation bad. She, however, wanted to avail herself of the chance an operation would afford, and on September 12, 1889, I operated. After careful preparations as to washing, shaving and vaginal antiseptics, the uterus was seized with a strong vulsella, but on account of the fixed condition could be pulled down but little, the neck was soon enucleated with instruments which I had made for the purpose.

The extensive adhesions were broken up with great difficulty, and the ligaments were so involved that it was necessary to remove them.

The hemorrhage was controlled by compression forceps, which remained on about fifty-two hours; no ligatures used; the vagina filled, as in all the other cases with iodoform gauze, and the woman put to bed. She at no time had so much fever after the operation as she had before, and she made a good recovery.

CASE V. Mrs. W., aged 38, born in France, first menstruated at the age of fifteen, never was regular; married at twenty-three, one miscarriage five years after caused by lifting a heavy weight, followed by metritis and peritonitis, was confined to bed two months, never fully recovered; no cancer history.

Began to complain of uterine pain and hemorrhage about three months ago, for which she had consulted physicians at various times, who had given her medicine and injections without relief. She consulted Dr. Frances R. Marx, who, considering the case cancerous, called me in consultation. On examination I found great tenderness; the whole uterus enlarged and fixed; cervix indurated and nodular, with very vascular granulations which bled freely from the slightest touch; there was a constant watery, bloody colored discharge, having a characteristic odor; the cancerous cachexia was well marked and the diagnosis of cancer was unmistakable.

Being informed of the nature of her case and the only remedy, removal of the uterus, she at once consented to an operation. She was sent to the Children's Hospital. December 3, 1889, I removed the uterus. On account of the large size and fixed condition of the organ, accompanied by the fact that the woman had never

borne children, the operation was a most difficult one. After enucleating the cervix and separating the adhesions to the bladder it was still impossible to pull the uterus down—the attempt to turn it over backward was equally unsuccessful. After a time, however, I succeeded in turning it over forward, having fixed one blade of the vulsella into the fundus and made steady traction. The broad ligaments were then clamped with compression forceps (no ligatures used), and the operation finished by cutting the broad ligaments. The vagina was packed with iodoform gauze and the forceps removed after forty-eight hours. This large fibrous tumor which you see in the fundus of the uterus is what prevented the uterus from descending and made it so impossible to turn it over backwards.

The operation altogether was very difficult, and the hemorrhage from this softened, vascular, broken down, cervical portion was excessive and uncontrollable during the operation. The woman, though exsanguine by the time the operation was finished, made a good recovery, and is at present enjoying very fair health.

The first operation was the only one in which I used the aneurismal needle and ligature in enucleating the cervix. In the other cases the enucleation was done with instruments which I made for the purpose.

My object in reporting these cases is to call attention to the fact that we have in hysterectomy a remedy even for cancer of the uterus; to assist in establishing hysterectomy as a legitimate and recognized surgical operation, and to hasten the time when the surgeon will as promptly and confidently resort to removal of the uterus for cancer as he does to the removal of the breast.

Of these five cases all were married women, four had borne children, while the fifth case had had one miscarriage.

About the frequency of cancer of the body of the uterus, as compared with that of the cervix, there is great diversity of opinion, as is also the case in regard to the merits of the operative procedure for cancer of the cervix—whether to remove the cervix only or to make hysterectomy.

A recent able writer on cancer of the uterus, Dr. John Williams, Professor of Obstetrics in Queen's College, London, strongly advocates amputation of the cervix when the cancer apparently in-

volves only the cervix, saying: "That it is possible to extirpate cancer from the uterus by supra-vaginal amputation, and that, in so far as the prevention of recurrence in the uterus is concerned, total extirpation of the organ presents no advantages over partial amputation."

It is not so surprising that Dr. Williams takes this ground, as he believes he has fully demonstrated that the tendency of cancer of the cervix is to spread laterally rather than to follow up the uterine cavity and involve the body of the womb. A careful examination by Professor Montgomery of the uteri of my cases does not go to confirm Dr. Williams' opinion, that in cancer of the cervix the tendency is only to extend laterally. Dr. Montgomery found the cancer cell extending up the mucous lining of the uterine canal.

While Dr. Williams advocates and practices the supra-vaginal amputation, he certainly has failed to make it clear how we are to diagnose with any certainty in which cases there is no cancerous involvement extending above the cervix.

There may be cases when this supra-vaginal amputation would be all that is necessary; in many cases, however, the cancerous tissue would not all be removed, and there is no means of differentiating the cases.

In connection with these cases, I will crave the indulgence for a word about laparotomy. Now, that laparotomy has become so common, no one thinks of making an elaborate and detailed account of this operation. In the past year I have, however, made three or four that are not devoid of interest to those who are interested in abdominal surgery.

Two of the cases appeared to be intra-ligamentous cysts. One very large, with no pedicle, was imbedded between the layers of the broad ligament deep in the pelvis. Enucleation was first attempted, but the capsule was so vascular that the attempt to shell it out had to be abandoned. I finally tied its whole broad base in eight sections. Including too much tissue in the last section next to the uterus, the ligature cut the tissues and the bleeding was profuse. After cutting away the sac close to the ligatures, I resorted to powdered Monsel's to stop the hemorrhage, which it did, using about three teaspoonfuls. A drainage tube was used, and the wound closed in the usual manner. There was

considerable inflammation, with a temperature of 104° for three or four days, when the fever subsided and the patient made a good recovery. She was out in five weeks. In the second intraligamentous case the cyst was small and there was no difficulty in enucleating it. The hemorrhage, however, was very profuse, and was again checked by putting Monsel's freely into the bed of the cyst. A drainage tube was used. Some fever followed, and the woman made a good recovery. These two cases made up my experience with Monsel's in the abdominal cavity. Just how to manage these intraligamentous cysts seems to be a matter for each indi-

vidual operator to determine after he has opened the abdomen and carefully examined the case at hand.

The third interesting case was that of a solid ovarian tumor weighing between seven and eight pounds. The woman, though very weak, made a good recovery. Professor Montgomery, after a careful examination, determined it to be fibroid. While solid ovarian tumors are not common, the fibroid variety is probably the least common of all. The most troublesome part of the operation for these solid tumors often is the management of the intestines, owing to the great length of the opening required to lift out the tumor.

CLINICAL LECTURES.

TALIPES FRACTURE OF ACROMIAL END OF CLAVICLE, DOUBLE FRACTURE OF SHAFT OF FEMUR, HARE-LIP.*

PROF. ROSWELL PARK.

This patient is a boy four or five years old who presents a well-marked case of talipes equino-varus. His parents have been too poor to provide proper mechanical support for the foot and the boy has worn a very cheap, inefficient shoe which has been of no use in correcting the deformity. They consulted me with reference to an improved form of shoe but I told them that I should not recommend a shoe until after an operation.

The question arises, is this a case in which the deformity is due to essential muscular weakness, or has the apparent atrophy of the muscles come about from lack of use of the foot? The peronei tendons on the outside of the foot and leg act like a bridle rein opposed to the tibiales tendons on the inner side. Naturally, if the peronei are paralyzed, the foot will be turned in and I think the present condition is largely due to such trouble. Even if the weakness of the peronei were not the original cause, the deformity is at least perpetuated by their present inability to overcome the pull of the tibiales.

After cleansing the foot and leg and applying an Esmarch bandage, I will cut the tendo Achilles by the ordinary subcutaneous method. You will ask why the

Esmarch bandage was used. Certainly not for the almost bloodless section of the tendo Achilles, but because I intend to divide the tendons on the inner border of the foot by an open incision according to the operation of Dr. A. M. Phelps, of New York. After doing this, you see that the slightest touch restores the foot to its normal position, the wound is closed by dusting iodoform over it and applying layers of iodoform gauze, bichloride gauze and cotton, and the whole is kept in place by a roller bandage. When the tourniquet is taken off, the blood will rush back into the foot and an aseptic blood-clot will be thrown out to heal the wound, which I have made.

This case being one due almost entirely to lack of muscular control of the foot, the bony deformity is not great and an operation on the tarsus is unnecessary. The foot is restored manually to its proper position and is held in a position of over-correction while I apply a plaster-of-Paris dressing. We have every reason to expect primary union under this dressing, by the organization of the blood-clot. The parents of the child must have directions about later using massage of the leg muscles to the best of their ability. Without some such means to stimulate the peronei and the sural muscles, the foot would relapse almost to its former state and con-

* Buffalo General Hospital Surgical Clinic, reported by A. L. Benedict, A. M., M. D.

siderable care must be taken to keep the foot in its restored position by making the external and posterior muscles do their proper work.

This patient has sustained a fracture near the shoulder joint, the result of a fall on the shoulder. The doctor who first attended him diagnosed fracture of the acromion and applied a dressing which was not disturbed till I saw the case two days afterward. It struck me at the time that the dressing could not keep acromion in place as there was no provision for pushing the arm upward against this prominent process. On removing the dressings to see how much the acromion had dropped from its proper position, I found that it had not dropped at all, showing that it could not have been fractured. On manipulation, I got obscure crepitus which I succeeded in localizing at a point within half an inch or so from the junction of the clavicle and the acromion so that we must modify the diagnosis and say that the case is one of fracture of the acromial end of the clavicle. You will ask what is the necessity of making such an accurate diagnosis. Because a corresponding accuracy of treatment is necessary. You must know what part is injured in order to know in what position to place the shoulder. If the clavicle is fractured, you must push the shoulder upward, outward and backward. If the acromion is fractured you must rather raise the arm in order to push up the broken piece.

On inspecting the shoulder, you notice very little deformity. Apparently, the fracture is so near the joint that the outer end of the clavicle is held by the coracoclavicular ligament and thus there cannot be much displacement. All that is necessary, then, is to hold the parts quiet by a simple retentive dressing. We have met this indication by part of the Sayre adhesive dressing passed around the arm and body, and, over this, a roller bandage has been applied and the hand is kept in a sling. I show you this case, not to call attention to any error on the part of another, for the original dressings were sufficient to keep the parts in place, but to emphasize the importance of making an exact diagnosis and to show you a comparatively rare and fortunate location of a fracture.

I also wish to call your attention to an interesting phenomenon and one which has here, something of a diagnostic value. Over the anterior and upper part of the chest you see an ecchymosis, not fresh as it would be from a recent superficial contusion, but showing the faded colors of an old extravasation of blood in which chemical changes have occurred. This is a common appearance after fracture of any bone, the blood working its way to the surface after several hours or after two or three days, according to the distance of the bone from the skin. Now, if the fracture had been one of the acromion process, the ecchymosis would be seen over the peak of the shoulder and posteriorly on account of gravitation while the patient is lying on the back. The blood could scarcely penetrate the deltoid muscle, so that the discoloration of the anterior part of the chest and the absence of such discoloration from the back and top of the shoulder are contradictory to the diagnosis of fracture of the acromion. Ecchymosis is practically of little value in the immediate diagnosis of fractures since it can not be seen till after the injury should have been located and the dressing applied.

This patient is a victim of the boom at Niagara Falls, having been injured while at work in the tunnel by a large stone falling on his thigh. The femur was broken in two places, just above the knee and ten or twelve centimeters higher. It is now six weeks after the accident and the case is brought before you as an illustration of the results of treatment. The patient is a young man of twenty-four, previously healthy and we should expect that the necessity for confinement and rest in bed has passed away. I wish, however, to manipulate the limb to determine the degree of consolidation and to make sure that it is sufficient to warrant leaving off the dressing. As I grasp the bone through the soft tissues, it seems fully twice as thick as on the opposite side, this increase in size being due to the callus which was thrown out after the double injury and which has been more or less organized into bone. In course of time, most if not all of this enlargement will probably be absorbed. As I rotate the leg at the knee, the trochanter moves in correspondence as it should if the femur is again one piece. Grasping the femur with both hands, I am

unable to make any motion in the middle, either by rotating it or by trying to bend the bone.

I also wish to measure the leg to note the shortening, a moderate degree of which is to be expected after any fracture of the femur and especially after a double fracture. We must be careful to get the legs perfectly parallel, having the pubes, umbilicus and internal malleoli in the same line. Measuring from the anterior superior spine of the ilium to the internal malleolus of the sound side first, I find the distance to be $33\frac{1}{4}$ inches. I make it a rule never to look at the tape-line until after I have determined by the sense of touch the exact points between which to stretch the line. In this way I avoid any possible self-deception. I find the measurement of the injured side to be thirty-three inches. By the dictum of the American Medical Association, a shortening of three-quarters of an inch is not a bad result and is quite consistent with the most skillful treatment. With a double fracture, it would not be at all surprising if an inch or an inch and a quarter of shortening had occurred. We must congratulate ourselves on having secured a minimum of it here. This has been obtained only by traction with a relatively very heavy weight, at first, of twenty pounds. Although consolidation has taken place, it would not be wise to allow the patient to get up and exert pressure on the bone, since some further shortening is still possible, but he can be relieved of the irksomeness of the bandage. His leg will be rested on a pillow and passive motion will be used so as to allow the knee to recover its mobility.

This case is a simple form of hare-lip occurring in a child aged sixteen months. The explanation of the trouble is easy if we understand a little about embryology. The two halves of the face are developed separately and grow toward each other. A cleft in the lip, like a cleft in the palate, indicates a failure of complete fusion of originally separate parts. In certain animals, the hare especially, such a failure is, so to speak, intentional. In the human being it constitutes an abnormality and, on account of the disfigurement, it is one which the surgeon is often called upon to remedy. The failure to fuse may be

present in any degree from a slight notch in the lip to a fissure extending up the side of the nose and backward through the palate to the pharynx. Such extreme cases of combined fissure of the face and palate are almost beyond the full restorative power of surgery. Hare-lip, as well as cleft palate, is almost never found exactly in the median line. Many mothers try to explain its occurrence by recounting some fright which they had late in pregnancy. The deformity, however, dates back to the fifth or sixth week of fetal life so that, without reference to the general possibility of maternal impressions affecting the child, such an explanation can not hold good in most cases of hare-lip and cleft palate.

The operation for the relief of hare-lip is in theory a simple one. It consists in freshening the edges of the cleft and sewing them together. In practice, however, this may be a very difficult plastic operation. I usually tell the parents that, although I can bring together the edges in any case of hare-lip, I can not ensure the union of the wound for the simple reason that the child in fretting and crying, may tear the stitches loose. We try to avoid this accident by reinforcing our stitches. Sometimes hare-lip pins are used to transfix the parts and a silk ligature is wound in figure-of-eight fashion over the ends of the pins. Sometimes sutures are passed through the cheeks and held by lead discs. Often the wound is dressed with iodoform and protected with collodion, and some rely on the stiffening of the collodion to prevent the child from moving the lip in crying. But the discharge from the nostrils or the saliva or food may loosen the collodion so that this dressing often fails.

Several operations have been devised to relieve different forms of hare-lip, all following the same general principle but differing in detail. For instance, we may cut parallel to one edge of the cleft, nearly to the margin of the lip and then turn inward so as to leave a tag of tissue at the lower part of the cleft. On the other side we do not remove as much tissue but we make a similar angle to aid in coöplating the parts.

In this case the defect is so slight, not extending to the nostril, that it is necessary only to freshen the margin of the cleft.

Our Continental friends have a way of operating on hare-lip without giving an

anæsthetic. I do not consider it any advantage to avoid the theoretical evil of giving an anæsthetic by allowing the child to suffer so much pain as the operation necessitates.

The alveolar border is not exactly regular, but is nearly so and it requires no operative interference. The teeth are not

quite regular and one is turned half way round and will require the attention of a good dentist at some future time. At present I forbear to do anything but rectify the labial fissure, lest with this rather feeble child I do too much, and perhaps totally fail. What remains to be done beyond this may be better done a little later.

COMMUNICATIONS.

CEREBRAL SYPHILIS.*

DR. J. E. HAYS.

I have prepared this paper with the object of presenting in as condensed form as possible, the history of two cases of cerebral syphilis that have lately come under my care.

An interesting feature of each case is the wide interval of apparent cure between the disappearance of the secondary manifestations and the beginning of the cerebral disturbance. As both cases were accompanied by paralysis which was hemiplegic in character, they forcibly illustrate the danger and serious effects that may possibly result from the product of a syphilitic dyscrasia.

CASE I. Mr. P., aged forty-six; an Englishman. I was called to see this case February 1st, 1892, and found him with complete paralysis of the left arm and leg; his power of speech was slightly impaired, and there was also some difficulty in swallowing. The attack had been sudden and was not attended by any loss of consciousness. Prior to the loss of power on left side, there had been no complaint of pain in the head; no vertigo; no staggering or uncertain gait; in fact, no symptom that would indicate an approaching paralysis. His general health for many years previous to the attack had been excellent; his habits had been regular; he used nothing alcoholic nor tobacco in any form; his occupation was that of foreman in a large manufacturing establishment in this city.

A careful inquiry into the previous history for something that would throw light on the cause of the hemiplegia revealed the following: At the age of twenty-six he contracted syphilis. The primary sore

was cauterized and internal treatment, the nature of which he did not know, continuously administered for several months. Following the initial lesion had been some glandular enlargements, slight falling out of hair, but no eruptions on the face or body. From the history it seemed to me that there could be very little doubt in regard to the nature of the lesion that had occasioned his paralysis, and he was at once given iodide of potash in gradually increasing doses. For two months his improvement was very satisfactory; in this time he had sufficiently recovered the use of his leg to enable him to walk about; but his arm was still almost powerless. He looked, ate, and slept well. The amount of iodide of potassium had been increased to forty grains three times a day. A larger amount of the remedy was badly borne, and it was decided to continue this dose. On the sixth of April he developed a severe pleurisy on the left side; this was attributable to an exposure immediately after taking a Turkish bath. Dr. Bailey saw the case with me a few times during this attack; an effusion of moderate amount took place in the pleural sac, but disappeared under treatment in a few days. On April 20th, pleurisy occurred on the right side; this was also attended by effusion, not as great, however, in amount, as that had been on the left side. Shortly after the disappearance of this, he was seized with a violent bronchitis which so closely simulated tubercular phthisis that for a while it was calculated to deceive, especially as the attack was attended by persistent cough, profuse yellowish expectorations, rapid loss of color and strength, night sweats and a fever somewhat hectic

* Read before Medico-Chirurgical Society, Louisville, Ky., Dec. 9, 1892.

in character. His treatment at this time was mainly the syrup of hydriodic acid, a generous allowance of port wine, and plenty of liquid food. Later he was also given the compound syrup of the hypophosphites. His improvement for several weeks was very slow; the chest symptoms did not entirely disappear until September. Since then, under the use of iodides and Paradism, he has made considerable progress towards regaining the use and strength of the paralyzed limbs. A few weeks ago he resumed his work at the factory.

CASE II. Mr. J., aged forty-two; carpenter. This is a somewhat similar case to the one just reported. I saw him shortly after the attack of hemiplegia, and elicited the following facts: Eighteen years ago he had an indurated sore on the penis; secondary manifestations followed, but slight. He did not remember the duration of the treatment, but said that he continued to take medicine until the physician pronounced him cured. Since abandoning the treatment there had been no further outbreak on his skin; he married and has a son living, aged fifteen, whose upper central incisors on examination showed the characteristic malformation of inherited syphilis, as described by Hutchinson. The patient's health, notwithstanding bad hygienic surroundings and habits, had remained in good general condition until last May. At this time symptoms of vertigo made their appearance, and soon became well marked and persistent. In walking he felt an almost continual tendency to pitch forward and to the left side; his mind frequently became confused and his memory was poor. On account of the dizziness he was compelled to quit his work. The physician to whom he applied for relief, overlooking the true cause of the trouble, and thinking that the vertigo was stomachal in origin, advised him to quit the use of stimulants to which he was somewhat addicted, live on a spare diet, and keep his bowels freely moved by the daily use of a laxative water, the Carlsbad preferred. This failed to give relief. On the 2nd day of June left hemiplegia occurred; complete loss of motion but no lessening of sensation of the arm and leg. There was no loss of consciousness, slight if any impairment of his intellectual powers; he could articulate distinctly, but talked slowly and with some

effort. There was no diminution in the acuteness of his vision.

The history given by the patient having established such a clear connection between syphilis and his present condition, he was at once given large doses of iodide of potassium. This was increased until he received as the maximum amount 180 grains daily. In addition to this he has at intervals also received a small or "tonic" dose of the bichloride of mercury, and Huxham's tincture of cinchona. His progress toward recovery has been rapid and uninterrupted; he has gained about twenty pounds in weight; feels well and can easily walk several squares without a cane. He has, however, regained but little use of the arm. He will probably never be able to resume his accustomed work.

The treatment of these cases presents no novelty. Clinical observation has long taught us that iodide of potassium is the sovereign remedy for bringing about an absorption of these products of syphilis. Its effect on gummata is well known and positive. While the mercurial preparations properly administered may aid, they do not approach in effectiveness the iodine compounds. Mercury, however, in the early stages of the disease has the supremacy. We very justly ascribe to it a direct and destroying effect on the virus of syphilis, whatever that virus may be. This being true, the opinion very generally prevails that it is only after a most careful, intelligent and prolonged treatment by mercury, that a physician can promise exemption from the later or so-called tertiary manifestations. In regard to a disease so grave in its possible results as syphilis, this fact ought not to be forgotten.

Black Eye.

There is nothing to compare with a tincture or a strong infusion of capsicum annuum, mixed with an equal bulk of mucilage or gum arabic, and with the addition of a few drops of glycerine. This should be painted over all the bruised surface with a camel's hair pencil, and allowed to dry on, a second or third coating being applied as soon as the first is dry. If done as soon as the injury is inflicted, the treatment will invariably prevent the blackening of the bruised tissue. The same remedy has no equal in rheumatic, sore, or stiff neck.—*Med. Times.*

SARCOMA OF THE BREAST AT THE AGE OF SIXTEEN YEARS:
OVARIAN CYST.*

A. M. CARTLEDGE, M. D.

I have two specimens to present, one of which I think is of special interest. A short time ago I saw in consultation a girl sixteen years of age, with the history that six months before there was observed in the right mammary gland a tumor the size of an ordinary marble, about midway between the nipple and the axilla.

Her physician, on account of the girl's age, kept her under observation for a while, but in the last month he noticed very rapid growth of this tumor, and at the last examination, a week or ten days ago, he observed one enlarged gland in the axilla. He also observed at the last examination that the superficial veins over this tumor were very much enlarged. The girl complained of lacerating pain. As I said she was only sixteen years of age, and apparently very robust in health.

On examination a tumor of a distinctly movable character, the size of a goose egg, could be felt in the breast indicated; it seemed as if you could grasp it and it could be moved separate from the gland substance proper, and it was slightly lobulated. Below this tumor was a distinct second nodulation with a groove between the two. It seemed to correspond, as it took a more backward direction, to the lymphatic vessels going from the breast to the axillary space. At this examination I only felt one enlarged lymphatic gland in the axillary region.

As to the question of diagnosis in this case, of course it would present some features of interest. Here we had a girl whose age was decidedly against malignant tumor of the mammary gland, with a clinical history of six months duration and of pain; enlargement of the superficial blood vessels and enlargement of the lymphatics in the axillary. From the history of the case I had no hesitancy in pronouncing it sarcoma. It presented every evidence of malignant growth and the age of the patient excluded carcinoma. There was no history of trauma.

Believing that all neoplasms of the breast, without exception, should be sub-

jected to complete extirpation and cleaning out of the axillary space, I advised this and the operation was done three days ago. The entire breast was removed, and you will observe that the tumor is distinctly encapsulated, entirely separate from the breast substance itself. The glands removed were simply the lymphatics. A thorough microscopical examination has not yet been made of the tumor.

Certainly the growth, as it appears since its removal, more than ever bears out the opinion that was conceived of it beforehand, and it has every evidence of a sarcomatous growth. The tumor presents some appearance of a fibroma superficially, but just beneath it we have this clear metastasis, with enlarged lymphatics showing its malignant character. The examination thus far has been a very rough one, the gentleman simply making a section without coloring it. He believed it would prove to be an interstitial mammitis of the breast, probably inflammatory. But the encapsulated condition indicates clearly to me that it is a sarcomatous growth, or a fibroma that has undergone sarcomatous degeneration, which we know is so common in this location. It does not present many features of an adenoma, but even this should be subjected to the same treatment.

The age of the patient is one of the most peculiar features. One gentleman, who has written on this subject, claims that the earliest age in any case of sarcoma occurring in the female mammary glands is eighteen years. However, there has been one case reported in this city at the age of fourteen. I am certain that all such growths will be considered malignant by me from a clinical standpoint.

CASE 2. This specimen is of greater interest to the general practitioner than to surgeons. My attention was called to the case while visiting another patient in the same house. The lady said she had been a sufferer with dyspepsia for a long time; that she had to live principally on fluids, etc. I thought I recognized in her face the peculiar expression indicating ovarian disease. I made a careful examination and found a clear case of cyst of the ovary.

*Read before Medico-Chirurgical Society, Louisville, Ky., Dec. 9, 1892.

Operation was performed to-day; tumor removed weighing between thirty and fifty pounds; there were no adhesions; patient bore the operation well; when she was taken off the table pulse was 80; she had no shock and nothing to indicate further trouble. This case is interesting from the

fact that the woman had never complained of anything except dyspepsia and there was nothing to indicate presence of the cyst, except the enlargement which might have been due to other causes. The patient never suffered any severe pain or inconvenience from the presence of the tumor.

CLINICAL AND EXPERIMENTAL CONTRIBUTION TO THE TREATMENT WITH CREASOTE OF PULMONARY TUBERCULOSIS.*

DR. ALBU, IN BERLIN.

In the Moabit Hospital in Berlin, creasote has been employed in constantly increasing doses since June, 1887, and especially latterly since the publication of Dr. Sommerbrod, in Oct. 1891, has the remedy been employed in many cases of various stages of the disease. The remedy was administered in pill form of 0.05 grammes each, and the average patient reached in the course of two weeks sixty pills per day. Many patients took 5,000 such pills in the course of a few months, and some even 9,000 pills, equal to 450 gramm (nearly a pint) of the creasote. No especial difficulty was found in the administration of these immense doses.

While Sommerbrod in the beginning recommended creasote only as a very useful remedy in the symptomatic treatment of phthisis, of late he urged it as a successful remedy against tuberculosis, by which in fact severe forms with cavities could be permanently healed. In a pamphlet of recent date he recommends creasote even as specific for tuberculosis, his recommendations being based upon clinical experience.

In view of this, experimental researches were made at the Moabit Hospital, and these, as well as the experimental investigations of P. Guttman, Coze and Simon, Sormani and Pellacani, Schüller and finally of Cornet, proved negative in the great majority of cases.

The author points out the importance of appreciating the effects really due to the remedy, in view of the natural variations in the clinical course of pulmonary phthisis, and finds that in a critical inquiry as to its effect upon the chief symptom which reflects the real disease process, *the fever*, the remedy is without any effect whatever, as it is also upon the

etiological factor of the disease. No material, lasting change in the presence of tubercle bacilli in the expectoration has been observed in any case; and under the continued administration of large doses of creasote the development of cavities, pneumothorax, amyloid degeneration, etc., has been observed; even in the early stages, the disease has frequently had a rapid course despite the treatment. On the other hand, the accomplished improvements were not greater than those secured under a purely hygienic-dietetic management—a conclusion which is based upon a great number of comparative investigations.

Under the favorable influence of the latter, improvement in the subjective and objective symptoms has been frequently observed in a short time; as for instance in a porter who under three different methods of treatment—tuberculin injections, hygienic-dietetic management, and large doses of creasote, each time gained from eight to twelve pounds in weight in the course of eight weeks in the hospital.

Creasote appeared to act favorably in many cases only through its influence upon the expectoration and digestion.

In common with Th. Weyl, the author demonstrated that the introduction of large doses of creasote into the blood is without influence upon the tubercular process in the lungs; the sputum from such cases having been found fully virulent for animals. Inoculation of such sputum into the anterior chamber of the rabbit's eye was followed by typical tuberculosis, and in all test animals tubercle bacilli were found in great numbers in the iris and cornea.

Intraperitoneal injections upon guinea pigs of sputum from patients who had taken many thousands of creasote pills, were followed by general, miliary tuber-

*Translated from the *Deutsche Medicinische Wochenschrift* for Dec. 15, 1892.

culosis, the latter being confirmed by bacteriological examination.

The results of the investigations which will hereafter be reported in detail in the *Zeitschrift für Hygiene und Infectious-Krankheiten* show beyond doubt, as do also the clinical results witnessed, that creasote is without influence upon the tubercle bacilli, and upon the specific tubercular process in the lungs.

Similar results with the same conclusions were reached in this country by Dr. Karl von Ruck, of Asheville, N. C., who made his investigations in his private institution for phthisical patients, and who speaks of his present employment of creasote in a recent paper as follows: "Crea-

sote is used only for its influence in overcoming fermentative processes in the alimentary canal, when less unpleasant means fail to succeed, and for its stimulating effect upon the mucous surfaces.

I have become absolutely satisfied that creasote has no specific effect upon the tubercular process and have demonstrated that inoculations with tubercle bacilli of blood serum from a patient absolutely saturated with creasote by large and long continued dosage show luxuriant growths of the germs, not differing from cultures in serum where creasote had not been given, also that the germs from such patient's sputum produce virulent cultures."—

SOCIETY REPORTS.

THE MEDICAL-CHIRURGICAL SOCIETY OF LOUISVILLE.

Stated Meeting of December 9th, 1892.

THE PRESIDENT, Dr. F. C. Simpson, in the chair.

URTICARIA.

Dr. D. T. Smith: This young man has been in excellent health since childhood, with the exception that he had spasms for a short time during infancy, such as any child might have. These spasms never occurred after he was two years old. He had no other form of illness until he was fifteen years of age, when he had an attack of malarial fever, which lasted two weeks, and after that an attack of typhoid fever.

Before the attack of typhoid fever he felt at one time an itching over the right orbit, and reaching up his hand to ascertain what it was, he felt a tumor about the size of a wine grape projecting. That tumor disappeared, then it came again, this time slightly larger than before, and immediately over the left orbit; disappearing and again appearing in his ear, then on his cheek, then on his lip, once inside of his mouth; two or three times on the back of his head, and when I first saw him about four weeks ago, the tumor was disappearing under the right eye.

These tumors are rather soft, except in the middle where there is a little more resistance to be felt. Four evenings ago he felt a twinge just over his right eye, and reaching up his hand felt the

tumor coming there. I saw it the next morning. It had then spread some and was projecting probably twice as much as you see now. It comes and goes very quickly—he will simply feel a little itching, put his finger to the spot and the tumor is there. There is no sore upon his skin; however, there is one little place which does not change, probably a mole, seemingly a little thickening of the skin forming a small lump. He compares these tumors as they pass away to the condition as observed in this spot that does not change.

DISCUSSION.

Dr. Wm. Cheatman: It looks to me more like urticaria than anything else.

Dr. W. L. Rodman: How long do these so-called tumors remain out—that is for what length of time can they be detected from external appearance?

Dr. D. T. Smith: Sometimes two or three days; at other times they will appear and disappear in a very short time. Probably the average time is about two days in one place.

Dr. A. M. Cartledge: It strikes me that it is a misnomer to call this condition a tumor. I do not think it can be properly classed as a tumor. When Dr. Smith first described it, I thought it was probably a blood extravasation. I have seen several cases of subcutaneous hem-

orrhage of the scalp which had some resemblance to this case. Since making an examination, however, I think it is neurotic. The case more properly comes under nervous irritation, or a vaso motor paresis.

DR. A. M. VANCE: I believe the trouble is urticaria; I do not see what else it can be; it looks and feels to me like urticaria.

DR. W. L. RODMAN: I am fully satisfied that these swellings are not tumors. The whole history of the case clearly excludes all possibility of tumors or neoplasms. No tumor could grow in so short a time, and disappear so rapidly. I take the view that Dr. Vance does, and am satisfied that it is a disease of the skin.

DR. D. T. SMITH: I agree in the main with what Dr. Cartledge has said: He stated, I believe, that it is vaso motor paresis. I think this enlargement is due to paralysis of the nerves controlling the capillaries and arterioles, allowing an accumulation of fluid in them, mostly blood. At first there is a little discoloration, and finally a very slight ecchymosis, the skin seeming to be involved to that extent. And yet this tumor has appeared once inside of the mouth. While the origin of the trouble is in the nerve control, yet I think it is remotely related to urticaria. Cases of this kind must be very rare, as there is so little record of them. I shall look further and it may be that I shall find some reflex cause. There is no organic change in the brain as shown by the migratory character of the tumor and the trouble must be functional. The reflex may be in the stomach, but I have not been able to find it. I have not examined the nose; however, there has been no complaint. The patient has been in perfect health, and I have been unable to find the least trace of history of any other trouble. I must still denominate this a tumor, though, of course, I am aware it has nothing of the nature of a neoplasm.

DR. A. M. CARTLEDGE reported a case of MAMMARY SARCOMA IN A GIRL OF SIXTEEN YEARS; ALSO A CASE OF OVARIAN CYST. (Page 88.)

DISCUSSION.

DR. W. L. RODMAN: I agree with Dr. Cartledge in what he says concerning his first specimen; I am satisfied from the appearance of the growth and its clinical

history there can be doubt as to its malignancy, and, being satisfied of this—whether it be carcinoma or sarcoma—the proper procedure was complete removal.

According to S. W. Gross, the youngest case in which carcinoma of the mammary gland has occurred was twenty-one years. This was in the practice of Henry. His statistics show the youngest case of sarcoma of the mammae to have been fourteen years of age. One case has been reported to this Society where the patient was not even thirteen years old. I think there is very little doubt about the specimen presented being a sarcoma, and the Doctor did the proper operation, removing the entire breast and cleaning out the axilla.

In reference to glandular enlargements in these cases, I disagree with Dr. Cartledge. While the rule is not to have involvement of the axillary glands in sarcomata of the breast, still there are other exceptions besides the case under discussion. Gross reports several I know. We also know that according to Butlin, sarcomas of glandular organs, especially the tonsil, testicle and lymphatic glands, are more likely to be followed by enlargement of the lymphatic glands than even carcinoma in like situations. The old idea that sarcoma never causes glandular involvement must pass away.

DR. A. M. VANCE: I agree with what has been said, and believe the condition of this tumor was such as to justify complete removal of the breast.

I would like to put on record a case I saw this summer: A very intelligent lady forty-five years of age, consulted me in regard to a tumor of the breast, which was hard and painful at the time. I gave the usual stereotyped opinion that all tumors of the breast in a woman over thirty, ought to be removed, and advised immediate removal. Operation was refused, and I did not see the patient for about a month, when she again called upon me. I made a second examination of the tumor and it was then about half the size it was at the first examination. I will say, however, on the occasion of her first visit to me I advised the removal of corsets, which she had probably been wearing tightly laced, as she was quite a fleshy woman. At the second examination, notwithstanding the fact that the tumor had considerably decreased in size, I still advised its removal. At that time she told me that

she attributed the disappearance of the tumor to the influence of prayer. In another month she returned and the tumor had entirely disappeared, and she wanted me to make a statement that I had examined her on a certain date, finding cancer of the breast; had examined her on another date and found the cancer about half of the size, and again on such and such a date when the cancer had totally disappeared.

This is the first case in my experience where tumor of the breast has disappeared. Dr. Hays will remember another case where the tumor was not in the breast but in the pectoral muscle just anterior of the axillary space. In this case both Dr. Hays and myself thought it was cancer and advised early removal. This patient consulted some "Faith Doctor," and the tumor entirely disappeared.

DR. W. O. ROBERTS: I am sorry that I did not hear Dr. Cartledge's report of the tumor of the breast. Of course the younger the subject the more apt it is to be sarcoma. We find many cases of sarcoma of the breast that have gone on for some time, and others which have grown very rapidly with no glandular enlargement in the axilla. I remember one case not very long ago where there was very rapid growth, so rapid in fact, that the physician in attendance took it to be an abscess of the breast and lanced it, evacuating nothing but blood. I afterward removed the growth and found no enlargement of the glands in the axilla. The character of the growth of course influences to a great extent the enlargement of the glands. We have glandular enlargement nearly always in melanotic sarcoma, which goes through the system not only through the blood, but through the lymphatics; we have this sometimes in other forms of sarcoma, but chiefly in the melanotic.

In this connection I would like to refer to the case of melanotic tumor removed from the groin of a very fleshy woman, which I reported some time ago, Dr. Rodman assisting in the operation. Within the last month there has been a recurrence of the disease, there are several tumors on the body but not at the point from which the original growth was removed.

Referring to what Dr. Cartledge has said about the ovarian cyst, I recently

reported a case where I operated upon an old umbilical hernia, the patient being an exceedingly fleshy woman and had not suspected ovarian tumor, nor had I, my attention having been directed to the irreducible umbilical hernia. During the operation for hernia the patient had a very severe vomiting spell, a great deal of the intestines protruding through the opening, and I detected a large ovarian tumor, which was promptly removed. My experience is that ovarian tumors are very frequently run across, just as in the case reported by Dr. Cartledge, by accident.

DR. D. T. SMITH: Dr. Douglass Morton used to insist upon a point in reference to removal of the glands in the axilla that seems to me entitled to much weight, that is the danger of recurrence in the axilla was so limited that it did not justify removal of the glands. I notice most leading surgeons, however, are still urging the course recommended by Dr. Cartledge—the removal of all the glands of the axilla at the time the breast is removed, making a complete operation. If it is true that in only three per cent. of the cases cancer returns in the axilla, then it does seem to me that the condition hardly warrants such a complete operation. I saw some time ago a report by Bigelow, I think, of Boston, where he had collected all the cases of cancer of the breast he could find, and only three per cent. of them had recurred in the axilla, all the rest recurring in the scar. In view of this, I think the complete removal of the axillary glands in all cases to prevent recurrence in so small a percentage, is hardly justifiable. I would like to know if any of the members present have any statistics on the subject.

DR. W. L. RODMAN: The best results which have been obtained in the operative treatment of malignant disease of the breast is by a free incision, removing all the glands, and also invading the axilla and removing all enlarged glands and other suspicious tissue. This done we get results second only to operations for the removal of carcinoma of the lip. Dennis' statistics made from a large number of cases of malignant disease of the breast treated by free incision are so good as to approximate in results operations for epithelioma of the lip, the best in the field of operative surgery for malignant disease.

DR. A. M. VANCE: In operations of this character at the Johns-Hopkins Hospital, I observed, while there recently, that they not only cleaned out all the lymphatic glands of the axilla, but also removed all the pectoral muscle on the side affected. Dr. Halstead claims that this is the only way you can hope to entirely remove the cancer. I believe that the wider you go the better it will be.

DR. A. M. CARTLEDGE: I have very little to say in closing. One point in regard to lymphatic enlargements in sarcoma, carcinoma and other tumors of the breast—there is something in what Dr. Smith says in that it gives a suggestion as to the causation of lymphatic enlargements in growths of the mammary glands. I am a firm believer that originally and primarily many tumors, and very much of the lymphatic enlargement of the axilla, are inflammatory in character from the absorption of pyogenic micro-organisms rather than from metastasis.

In regard to cleaning out the axilla, I think the best way to prove to Dr. Smith that this should be done, is that twenty-five years ago the percentage of recurrence in removal of cancers of the breast was so great, that many of the best surgeons advised against the operation. Later they removed the cancer and the lymphatic glands, and their percentage of recoveries was still greater. Now they go still further than this and remove the pectoral muscles and the results are more satisfactory. I believe that the more structures you remove, within reason, the better the result will be.

DR. D. T. SMITH: It still seems to me hardly necessary or justifiable to remove the pectoral muscles and lymphatic glands in these cases, considering the small percentage of recurrence in the axillary region. In the older operations spoken of by Dr. Cartledge, I am forced to believe that if there had been more complete removal of the cancer itself, the percentage of recurrence would have been much less.

DR. A. M. CARTLEDGE: If you remove a cancer of the breast ever so thoroughly and then slit up the enlarged lymphatic glands and submit them to a microscopical examination, usually cancerous elements will be found there.

DR. J. B. HAYS read a paper on "CEREBRAL SYPHILIS." (Page 86).

DISCUSSION.

DR. A. M. VANCE: I only want to speak of one thing that has been brought up by the paper. My experience proves to me the importance of mercurial treatment in these cases just as much as in the primary stage. I believe that a patient suffering from syphilitic trouble must take about so much mercury before he can be entirely relieved. Though iodide of potassium might bring about the same results, it is a question whether such results would be permanent. While we all know the good effects of iodide of potassium in these cases, it is my opinion that if mercury were given in proper doses from the beginning of the first symptoms, the results would be better and more permanent.

DR. A. M. CARTLEDGE: I would like to ask Dr. Hays how much mercury he would advise in these cases, and the dose given in these cases, and the cases referred to.

DR. J. B. HAYS: I believe the dose has to be regulated as to quantity by each individual case. I gave in the two cases reported one-fiftieth of a grain.

DR. C. W. KELLY: I have never given mercury in any stage of syphilis; I much prefer iodide of potassium, and believe this will produce much more satisfactory and more certain results.

DR. W. O. ROBERTS: I think in these cases we should push iodide of potassium to the extent that the patient is able to bear it. I had a case of brain syphilis some time ago with Dr. Bodine in which we steadily increased the quantity of iodide until the patient took one and one-half ounces per day—one-half ounce at a dose three times a day. This quantity produced no trouble in the alimentary tract, but he had most excessive dysuria, passing enormous quantities of water during the time he was taking these large doses of iodide; it was given very largely diluted. This treatment cleared up the brain entirely; the man is now seemingly in perfect health; has since married and has two children.

DR. WM. CHEATHAM: It is my practice to treat syphilis, in either the first, second or third stage, with a combination of iodide of potassium and mercury. I believe that in brain syphilis mercury given by inunction will produce better results than when given by the stomach.

DR. A. M. CARTLEDGE: I am satisfied in my own mind that while we all have about

the same things to use in the treatment of syphilis in the various stages, first, second or third, the remedies, mercury and iodide of potassium being the chief, the manner in which we use them has a great deal to do with whether we have success or failure. In those cases where we have deposits pressing upon delicate structures, where it is desirable to remove them very quickly, such as the cases referred to by the essayist, I believe that we get the most rapid results by confining ourselves to the one remedy, iodide of potassium. I think mercury is a valuable agent in syphilis, but there is a difference in the action of these two agents. One point that I desire to call especial attention to is this, that at the same time we are administering iodide of potassium, we should also establish systemic drainage; this can be accomplished by two-grain doses of calomel. I also think quinine may be given in these cases with a great deal of benefit.

DR. S. C. DABNEY: I see a good many cases of syphilis in the tertiary stage, and occasionally meet with the secondary form in diseases of the eye, nose and throat, less often in the ear. In these cases I have used mixed treatment with good results. I will mention as a fact of some interest a case of syphilis I saw recently in which there was paralysis of one of the muscles of the eye within four months after the first inoculation. The ocular paralysis developed earlier and more rapidly in this case than it usually does. Disorders of the ocular muscles and of the pupils are common symptoms in brain syphilis, but as they did not occur in the cases reported by Dr. Hays, it would probably not be in place to discuss them here.

DR. D. T. SMITH: In my experience I have have only seen one case of brain syphilis; this patient was about thirty-six years of age, a carpenter by trade. Diagnosis was made of cerebral syphilis, which was first noticed by his staggering walk. I had him under observation for nearly three years and think there could have been no doubt as to the diagnosis. He was given large doses of iodide of potassium, probably up to twenty grains three times a day; I also pushed corrosive sublimate up to one-sixteenth of a grain. He went back to his work under my treatment. He fell from a house at one time being pretty badly crippled, which may have had something to do with aggravating the

trouble. After that he grew better, then worse and finally became insane and was sent to the asylum, where he died. I believe in these cases of cerebral trouble we may very often be mistaken in the diagnosis, as to whether there is a syphilitic lesion or not.

DR. C. SKINNER: In treating syphilitic cases, I give mercury by inunction preference in the second stage; iodide of potassium in the third and nothing in the first. My reason for giving nothing in the first stage is to be positive about the diagnosis. I use mercury in the second stage by inunction which I think is the best way to give it, keeping the bowels open and saving the stomach. In the third stage I give large doses of iodide of potassium, gradually increasing. I will mention a case of cerebral syphilis in which a man failed to carry out directions, which is just in line with Dr. Hays' paper. I treated this man's wife in an abortion; some time afterward I attended her in a second abortion; then she came to me in her third pregnancy and wanted me to bring about an abortion to avoid carrying the child to full term. Of course I told her I could not do this, but would try and tide her over the critical period. I put her on treatment with bichloride of mercury, in one-thirtieth grain doses three times per day, through the whole period of gestation. She then left the city; returning some time after she again become pregnant, and I treated her in the same way through that period of gestation; a perfectly healthy child was born and now shows no signs whatever of syphilis; the child is now five years old. I give the history of the man: At that time he gave me the history of having contracted syphilis twenty years before. This had apparently been cured, no further symptoms having developed until about two and one-half years ago, when he showed signs of syphilis in his walk, loss of memory, etc.; he said he could not remember anything. I recognized what I thought to be a manifestation of return of the trouble, and put him on iodide of potassium. He improved very rapidly at first, so much that he discontinued the use of iodide and passed out of my notice for a while. Finally he came back to me with a return of the trouble, and I again gave him iodide of potassium, gradually increasing the dose. He again improved and left off the medicine.

entirely. I was hurriedly called to his house some time afterward, and found the man in convulsions, and he died in about four or five hours. His wife told me that he had not been taking medicine of any kind for about six months. I have since learned that he discontinued the use of iodide on the statement of the druggist from whom he purchased the drug, that he was consuming a dangerous quantity less, (I think he was taking about four drachms three times per day), and if he did not quit it would kill him.

DR. J. M. RAY: I have seen a large number of cases of ulceration of the mucous membrane of the upper respiratory passages from syphilis, and must say that I believe iodide of potassium does more good than anything else. It has been my practice to give mercury and iodide separately in these cases. I give iodide for an express purpose, and continue giving it until the desired results are obtained; until the ulcerated surfaces heal up. I continue the iodide as long as I have any

local lesion present, then give mercury. I will make here a brief report of an interesting case I saw some time ago. It was a case of syphilis in which there was ulceration of the mucous membrane of the nose with sloughing of the turbinated, and, at the same time, a chancre on the penis.

DR. J. E. HAYS: I have had only a few cases of the kind; I believe two in addition to the ones reported, since I have been practicing medicine. I have never given mercury a trial in any tertiary lesion, excepting in the last case referred to in the paper. I must say, however, that iodide of potassium has never failed in a single instance. I believe that is the best known remedy in removing syphilitic infiltrations. I simply gave mercury in this case as an experiment, not having very much faith in its efficiency. I believe, like some authorities, that if mercury would destroy the germ of syphilis, if given early, we could do away with all these latter manifestations, that is, the so-called tertiary symptoms.

CORRESPONDENCE.

REVIVAL OF "HEATONISM"; HERNIAL INSTITUTES AND SUBCUTANEOUS INJECTION FOR HERNIA.

EDITOR MEDICAL AND SURGICAL REPORTER:—We have recently seen through an exchange, (the New York *Medical Journal*, Jan. 7th, 1893,) that "Heatonism" and rank, downright quackery has again invaded the domain of Hernial Therapeutics. This time, however, in a more bold and defiant manner than Heaton ever dreamed of; for he published his wonderful (?) cure in the public press only.

In a nutshell, we are told by Dr. Wm. C. Kloman, of Baltimore, that a new method of treating hernia by the hypodermic injection of irritant solutions has enabled him to cure chronic old herniæ, which have been previously irremediable; that the method was equally successful in both sexes at the Institute (?) and that it was even equal to the cure of strangulated hernia.

Now, the most preposterous assumption, in connection with this so called, new nostrum, is the claim that the wonderful dis-

covery belongs to Dr. Chas. McCanless, of Atlanta, Ga.

This may pass when addressed to those who know little or nothing of hernial literature; but to those of us who have, at least a rudimentary acquaintance with that part of the history of our art, it certainly is news. Nevertheless, in all fairness, to the memory of Boston's notorious hernial quack, we are bound to ask for information and beg to know in what particular the new (?) method differs from Heaton's injections?

Aye! It not only is Heatonism reproduced as far as technique goes; but it smacks further of methods of Heaton inasmuch as it does not state in the article above cited, what is employed as an injection-menstrum.

Is it intended, Koch-like, to withhold the great secret until its utter worthlessness is shown; or, like Prince Mattei, carefully guard its secrecy against the whole world?

It is not generally known that Dr. Heaton, of Boston, was the first who ever employed invagination of the hernial sac, and employed subcutaneous injections along the inguinal canal on a large scale for hernia. And he claimed he could cure all reducible herniæ. He, however, never pretended that he could treat a strangulated hernia in this way. The whole world stood amazed at his wonderful cures (?)—these cases in which a patient after spending a month in bed got up with his hernia remaining out of sight so long as a truss was worn;—which permitted him time enough to write out a testimonial to the doctor. But the old gentleman was finally prevailed upon to write a book or to supply the data for one. This he did; when the whole thing fizzled out and the world, at last, saw the secret, that the mystery was the talisman, and that the whole thing was little else than a piece of downright imposition.

If something has been discovered which will cure certain varieties of hernia, by all means give the world the benefit of it; but don't thrust on us, as a new discovery, a revamped relic of Boston Quackery.

VERITAS.

False Neurasthenia.

Dr. Myrtle writes as follows upon this subject: "We may find symptoms in every respect similar to those of true neurasthenia, and it will take you all your time and patience, as well as tact, to detect the sham from the real. If you look back a bit, you will find that as a child she showed temper; as she grew, she became fitful, hysterical, and given to the sulks; craved for sympathy, and exhibited little or no sympathy for others. On questioning her, she describes her sufferings in forcible language. She can neither eat nor sleep; has not an atom of strength; suffers from the most dreadful pain, most fearful headaches, and frightful spasms, and should you suggest any portion of her body from her head to her heels, as possible exempt from pain; she often resents the insinuation, and declares that is the very part where she suffers most. While she tells you all this in a sort of whine, her features don't show indications of any agony, and, if you watch her, you will find that she overacts her part. Utterly indifferent to the anxiety of parents and

friends, or to the trouble and expense she causes, she seemingly finds gratification in watching the unwearied efforts of those around her in doing their best to comfort and help her. While putting on an air of the most abject listlessness while you look at or speak to her, if you talk to her you will learn that she has both eyes and ears; if you assist her in any way she makes herself as helpless as she can—a dead weight. These creatures not only deceive every one around them, but in time they succeed in deceiving themselves. Were it not so, I cannot understand how they continue playing such a sorry game for so long, and with so much strain and fixity of attention, to the exclusion of everything else, as I have seen them do. If we push our inquiries a little further, we generally discover that there is some obliquity of the moral sense; an ungratified whim or disappointed affection at the bottom."—*Ex.*

Thiol in the Treatment of Burns.

Bidder (*Archives für Rhinische Chirurgie*) says that in treating burns a dressing should be selected which has the following qualities:

- (1) Should not require frequent changing.
- (2) Relieve pain.
- (3) Act as a drying substance.
- (4) Harden the new skin.
- (5) Hinder the growth of micro-organisms which may have gained entrance to the wounded parts.

The remedy which he has found to possess all the equalities is *Thiol* which may be used in two forms, liquid and powder.

In burns of the first and second degree, where the blebs are still intact, it is only necessary to brush the burned area with equal parts of liquid thiol and water and cover with wool. At the end of eight days the dressing should be changed, and again re-applied if the blebs have not healed. If the blebs have been ruptured and the corium exposed, all loose skin should be cut away and the burned area carefully cleaned; it should then be brushed with liquid thiol, and powdered with salicylic or boric acid and then with powdered thiol, and the whole covered with vaseline, cotton wool, and bandaged. As a rule, one or two dressings are necessary before the wound has healed.—*Ex.*

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SATURDAY, JANUARY 21ST, 1893.

EDITORIAL.

THE QUARANTINE PROBLEM.

There is always much gained when an important measure reaches the point of serious discussion. There is then hope for common sense conclusions. The discussion of the very important question of a National Quarantine is taking practical form in the halls of our National Congress, and there is an assured promise that a measure, bearing the *ear marks* of practical statesmanship, will be adopted.

The question is not one limited within the corporate lines of any city or the bounds of any one state. It is one broader even than our national domain. It should be treated nationally, distributing the burden of an effective quarantine over the entire people, thus mitigating features that would otherwise prove oppressive to distinct communities.

The difficulty of building efficient barriers against Asiatic cholera is recognized by all scientific men. The inefficiency of local quarantine was thoroughly demonstrated last summer. The quarantine at New York was as efficient as it was possible to make it with inadequate means, imperfect methods and the discreditable jeal-

ousies of officials, yet it did not keep the cholera out of New York City. There may be pestilence in politics but there are no politics in pestilence. The opposition of local or city health authorities to those of the Federal quarantine was forcibly illustrated by many little episodes in New York's experience.

A notable fact was, that after the issue of the President's proclamation of national quarantine, no passenger vessel brought a case of cholera to this country. It had the good effect of enforcing more care abroad. It was a warning that crossed the Atlantic—a notice to all passenger carrying steamships that American ports were closed to all vessels carrying pestilence and that they would remain closed until all danger was passed.

There is a provision of our Federal Constitution which imposes upon Congress one of its highest and most sacred duties, that is, to "provide for the common defence and general welfare of the United States." We take it that the general health comes within the provision for the "general welfare," and that this clause gives the power

to establish a system of rigorous, and as far as human measures are possible, effective quarantine.

Dr. Watson, chairman of the International Quarantine Committee, reported that there is not a single port on the North Atlantic coast that is supplied with all the requisite means and methods of modern maritime sanitary science. He gave to Philadelphia the credit of being the best supplied of any port in the country.

Certainly our experiences, modern science, the stimulus of recent menaces of pestilence, have substituted greatly improved for antiquated methods,—importers and reporters to the contrary notwithstanding.

The question of the further improvement of methods and appliances and their efficient application is the one that at present most concerns American communities.

Reason and humanity dictate that we use every device and method approved by science and experience in protecting the public health. Our precautions should be taken before we are confronted by conditions of terrible peril; they will be too late when pestilence has secured a foothold.

A double quarantine is not objectionable. To approach completeness it should be both local and national, with the hearty and vigorous coöperation of all authorities to whom the work may be intrusted.

With a coast as extended as ours, cases will be likely to break through however vigorous the quarantine may be. The Federal authorities will have in their possession the better means and facilities of enforcing essential measures, and will command more respect than can or will local authorities. This respect would the more specially be felt abroad and would further have the good effect of keeping away from our shores a very undesirable class of people. Local resources are often limited, and there

is a lack of the implements or plants for adequate and quick disinfection.

The effective guarding of the country against epidemics necessarily involves many risks and hardships. The distress of a stringent quarantine must, in the very nature of things, be seriously felt in all trade and commercial centres. This fact presses the importance of placing the discharge of all the duties of quarantine authority in the hands only of men of the highest character and intelligence; men wise, quick and prompt in the discharge of duty, and that without fear or favor; men above the motive of selfishness, of local or trade jealousies. Neither the interest of the individual, nor of any class of individuals, nor of any one or more communities should be allowed to stand in the way of the "general welfare."

While there exists no reason for undue alarm, neglect to take precautions against the possible visit of an epidemic would be crime. Philadelphia has had three visitations of Asiatic cholera, 1832, 1849, 1866, and has no assurance of exemption in the future. The responsibility vesting upon our local authorities cannot by them be over estimated.

Cleanliness is the one great foe of cholera. Filth has many lurking places and should be routed out and destroyed. Every disease breeding hole and corner should be disinfected. Active practitioners of medicine can exercise a potent influence in this line. They have been made painfully familiar with the causes of many of the terrors with which they have to deal—they know where lurks the fruitful source of pestilence, and, where they will to exercise it, they have an effective voice in its removal. Diligent efforts in the way of sanitation should be made in every city, town and village. In our own city, health, good morals, great trade and commercial interests are involved, and *cleanliness* will do as much,

if not more for us, than quarantine with its embarrassing restrictions.

It has been estimated that a complete quarantine will eliminate seventy per cent. of the probability of the introduction of cholera. Certainly the other thirty per cent. can be prevented by cleanliness and the practice of the best known principles of preventative medical science.

London, the great commercial centre of Europe, toward which tend all the roads of the old world, had but ten deaths from cholera in 1892. In our own city the deaths from diphtheria have doubled and quadrupled that number in one week. Our house cleaning will keep out the foes of public health.

The Senate Bill places the matter of national quarantine where, under existing conditions, it should be. There is no more intelligent, scholarly and scientific a set of men in the country than the medical authorities in the marine service.

The following from the Report of the Senate Committee in epidemic diseases, is worthy of thoughtful reading:

"The committee is satisfied that an effective and uniform system of quarantine regulations vigorously enforced at all ports and places having commercial intercourse with foreign countries is absolutely necessary as the only means of preventing the importation of contagious and infectious disease into this country from other countries, and that a perfect and uniform system is equally necessary to prevent the importation of such diseases into one State from another.

Some of the States have adopted systems of quarantine regulation which, in the opinion of the committee, are sufficient, so far as treatment at the port of entry is concerned; but many others have no quarantine regulations whatever, and if a single gate is left open to the introduction of such diseases the whole country may suffer the disastrous consequence of fatal epidemics.

Scientific investigation has asserted that neither yellow fever nor cholera originates in this country, but that if either is imported, under certain atmospheric conditions they will take root and spread with disastrous rapidity and fatality.

The most important of all considerations is to keep them out, and in the opinion of the committee the only means of effectually preventing their importation is a thorough system of national quarantine, which shall be uniform and enforced with vigor at every point of intercourse with foreign nations, and equally uniform and equally enforced as between States.

State quarantine authorities have been jealous of any interference by national authority with their quarantine regulations, and those of New York and New Orleans have heretofore steadily opposed any national control of the subject.

The quarantine regulations of these States give a large revenue to these States or to their boards of health, and for that reason, if for no other, they may be expected to oppose national control.

Now, however perfect their systems of regulations and the systems of other States may be, they are but the systems of a small proportion of forty-four States.

The forty-four States need, demand, and are entitled to protection from this importation of disease.

The eighth section of article one of the Constitution of the United States provides that—

Congress shall have power to regulate commerce with foreign nations and among the several States and with the Indian tribes.

The regulations proposed by this bill are strictly regulations of foreign and interstate commerce and nothing more.

The transportation of a person or any article of merchandise from any foreign country to this country, or from this to any foreign country, is an act of "commerce with foreign nations," and the transportation of persons or property from one

State to another is an act of "commerce among the States."

This bill proposes to so "regulate com-

merce with foreign nations and among the several States" as to strip it of contagion and infection.

NATIONAL QUARANTINE.

The Quarantine Bill passed by the United States Senate, Tuesday, January 10th, consists of ten sections of carefully framed legislation which seem to us to provide reasonable security for the public health from the invasions of infectious or contagious diseases. It provides for medical inspection of all vessels both at the port of departure and that of entry, and requires from each a clean bill of health, thereby protecting the country against infection from abroad. It authorizes the establishment of quarantine as between the States, so that if such disease should effect a land-

ing, its progress may be stayed. It abolishes the National Board of Health, and puts the whole subject under the control of the President of the United States, with ample power for needful details in the hands of his Subordinate, the Secretary of the Treasury, thereby making prompt action possible in any emergency. It provides for adequate penalties for the violation of the law or of any regulations established under it; and appropriates \$1,000,000 to carry its provisions into effect, thereby, putting power behind all its provisions.

RESUME OF MEDICAL PRACTICE ACTS IN THE DIFFERENT STATES AND TERRITORIES.

In response to numerous requests we give the following, taken from *Medical Education*, etc., published by the Illinois State Board of Health, 1891.

ALABAMA.—Examination by the State Board of Examiners, or by a County Board of Examiners. Law passed in 1877.

ARIZONA.—Register diploma with County Recorder. Passed in 1881.

ARKANSAS.—Registration of diploma or examination by the State or a County Board of Examiners (latter inoperative). Law passed 1881.

CALIFORNIA.—Certificate on diploma from a college in "good standing" or examination by one of the three Boards of Examiners. Passed in 1876.

COLORADO.—Certificate on diploma of college in "good standing" or examination by the State Board of Medical Examiners. Passed in 1881.

CONNECTICUT.—No law except against advertising itinerants.

DELAWARE.—Registration of diploma in a County Clerk's office. Passed in 1883.

DISTRICT OF COLUMBIA.—Endorsement of diploma or examination by committee of the District Medical Society (practically inoperative). Passed in 1838.

FLORIDA.—Examination by one of the State or District Boards of Medical Examiners. Passed in 1884, 1889.

GEORGIA.—Registration of diploma in the office of the Clerk of the Superior Court. Passed in 1881.

IDAHO.—Record diploma at county seat. Passed in 1887.

ILLINOIS.—Certificate on diploma from college "in good standing" or examination before the State Board of Health. Passed in 1877, 1887.

INDIANA.—Registration of diploma in County Clerk's office. Passed 1885.

INDIAN TERRITORY.—(a) Cherokee Nation: Examination by the Board of Examiners of the Nation. Passed 1878. (b) Choctaw Nation: Certificate on diploma or examination by the Board of Examiners of the Nation. (c) Creek Nation: No law.

IOWA.—Certificate on diploma from college "in good standing" or examination by the State Board of Medical Examiners. Passed 1886.

KANSAS.—No law.

KENTUCKY.—Ten years' practice, or registration and endorsement of diploma of a legally chartered college by Secretary of the State Board of Health. Passed 1874, 1888, 1890.

LOUISIANA.—Recording diploma before County Clerk or Justice of the Peace after endorsement of same by State Board of Health, which is "required to certify to the diploma of any medical institution of credit and respectability without regard to its system of therapeutics." Passed 1882, 1889.

MAINE.—No law.

MARYLAND.—Verification of diploma of "college in good standing," or examination by State Board of Health (law inoperative). Passed 1888.

MASSACHUSETTS.—No law.

MICHIGAN.—Record diploma in County Clerk's office. Passed 1883.

MINNESOTA.—Examination by State Board of Medical Examiners. Passed 1883, 1887.

MISSISSIPPI.—Examination by a County Board of Medical Censors. Passed 1882.

MISSOURI.—Certificate on diploma from college in "good standing" or examination by State Board of Medical Examiners. Passed 1883.

MONTANA.—Ten years' practice, certificate on diploma from a college "in good standing" or examination by State Board of Medical Examiners. Passed 1889.

NEBRASKA.—Register in the office of the County Clerk. Passed 1881, 1883.

NEVADA.—Register diploma before the County Recorder. Passed 1875.

NEW HAMPSHIRE.—License from the Board of Censors of Medical Society.

NEW JERSEY.—Examination by the State Board of Medical Examiners. Passed 1880, 1888, 1890.

NEW MEXICO.—Endorsement of diploma or examination by Territorial Board of Examiners. Passed 1882.

NEW YORK.—Examination by one of the State Boards of Examiners, after September 1, 1891. Endorsement of diploma until September 1, 1891. Law passed 1880, 1888, 1890.

NORTH CAROLINA.—Examination by the State Board of Medical Examiners. Passed 1889, 1885.

NORTH DAKOTA.—Examination by the State Board of Medical Examiners. Passed 1890.

OHIO.—Law inoperative.

OREGON.—Certificate on diploma from a college "in good standing" or examination by the State Board of Medical Examiners. Passed 1889.

PENNSYLVANIA.—Registration of diploma before County Prothonotary after endorsement (of diploma from college outside of State) by some Medical College within the State. Passed 1881.

RHODE ISLAND.—No law.

SOUTH CAROLINA.—Examination by the State Board of Medical Examiners. Passed 1881, 1888.

SOUTH DAKOTA.—Certificate on diploma, or examination by the Territorial Board of Health. Territorial law 1884.

TENNESSEE.—Registration after certificate on diploma of college "in good standing" or examination by State Board of Medical Examiners. Passed 1889.

TEXAS.—Registration after endorsement of diploma, or examination by a District Board of Examiners (practically inoperative). Passed 1876, 1879.

UTAH.—No law. (Recent enactment requiring examination not at hand.—Ed.)

VERMONT.—Registration after endorsement of diploma, or examination by a Board of Medical Censors appointed by either State Medical Society. Passed 1880.

VIRGINIA.—Examination by State Medical Examining Board. Passed 1884, 1888.

WASHINGTON.—Examination by State Medical Examining Board. Passed 1890.

WEST VIRGINIA.—Certificate on diploma of "reputable" college, or examination by the State Board of Health. Passed 1882.

WISCONSIN.—Examination or endorsement of diploma by the censors of any State or County Society. Laws of 1878, 1881.

WYOMING.—File record of diploma with Registrar of Deeds. Passed 1886.

In Minnesota, Montana, North Dakota and Washington every applicant for license to practice must have attended three courses of lectures. The same will be required by the California Boards after April 1, 1891; the Colorado Board after July 1, 1893; by the Illinois and Iowa Boards after the session of 1890-91 and by the Boards of Examiners of New York after September 1, 1891. There will probably be three more State Examining Boards in the next year.

TRANSLATIONS.

GONORRHEAL INFECTION—MODES OF EXTENSION.

There is no doubt that blennorrhœa in women is of more frequent occurrence than is generally accepted and that its results are more extensive than was formerly taught. It has been shown that blennorrhœa in the female can involve the entire genital tract—the uterus, tubes, ovaries and even the neighboring peritoneum may be attacked by acute inflammation. It has also been shown that women in the first days of their married life have been infected by their husbands, who, since they had no discharge, had been declared by their physicians to be cured, or who married when they themselves felt satisfied they were no longer diseased. In this manner many young women begin to suffer more or less from the early days after

marriage to the end of their natural life. Menstruation becomes abnormal; the uterus and its adnexa undergo inflammatory changes; the wife may abort frequently or remain sterile, or she may bear one or two children, and the puerperium may be complicated with inflammation.

A large number of such unfortunate women present themselves to us and often try our patience to the utmost. They frequent the various sanatoria and markedly increase the percentage of the nervous hysterical women. Their sterility, from the social standpoint, is really deplorable, since large families die out and the population is much influenced. That women so affected can still become pregnant no one doubts, but that blennorrhœa produces pathological changes in the uterus,

tubes and ovaries has been demonstrated also beyond a doubt.

In relation to the diagnosis and course of this disease the author differs from Zweifel, Saenger, Fritsch and others. It is remarkable that these eminent men have, by various theses, explained the origin of blennorrhœa as accepted to-day in almost the same words as those of Næggerrath; and we to-day understand the etiology of the microbes of blennorrhœa. According to their investigations, blennorrhœa in the male will exist a long time after infection without any symptoms being present. This is termed latent blennorrhœa and will induce in the female also a latent blennorrhœa, which may not produce any symptoms for months, oft times none, until marked disease of the uterus and its appendages attracts the attention of the physician. In such the secretions show no gonococci.

Dr. Feleki contends that latent blennorrhœa exists neither in the male or female, but that the male may have an urethritis of either a contagious, acute, or chronic character, or no blennorrhœa; or he may have, resulting from an old blennorrhœa, the pathological changes which cause the urethritis.

Inflammation of the urinary tracts of an infective character in the male, even if of some years standing and showing no discharge, will produce in the female a typical, not latent, attack of blennorrhœa. The definite diagnosis of blennorrhœa in chronic cases can only be secured when gonococci are found in the secretions or urine.

In the initial stages of blennorrhœa, gonococci are always found; and in the chronic stages, they are always present, except in those cases where the catarrh is no longer present, but pathological changes can be thoroughly demonstrated, or where other affections are present which change the character or cause of the secretion.

The author having studied this subject for several years has arrived at the following conclusions:

First. Chronic blennorrhœa in the male, even if no other symptoms are present, has the occasional appearance of gonococci in the urine, and will produce in the female a typical attack of blennorrhœa.

Second. If the secretion from the urinary passages of the male contains no gonococci, there will be no direct attack of blennorrhœa in the female.

Lastly the author calls attention to an affection which has received very little study of late, namely, pseudo-gonorrhœa. It is known that an infectious urethritis can exist in the male, the secretion of which will show no gonococci throughout its course. It is questionable whether this appears in the female. As facts directing the attention to this point the author cites Ophthalgo - Blennorrhœa Neonatorum. Investigation has shown that this disease from its etiology and course could be divided into two groups. In the group which could be classed the severer, the gonococci could be found in the secretion, while in the cases of lighter form the microbe could not be found. The question naturally arises if in these lighter forms the cause was that of pseudo-gonorrhœa.—(*Wiener ärztl. Centr.—Aus.*)

Vermiform Appendix Containing a Foreign Body Found in a Hernia.

H. Schmidt (*Munch Med. Wochen.*, 1892). The vermiform appendix is rarely found within a hernia, but few cases having ever been recorded in medical literature. The author reports one case. A woman aged 53, who had a right inguinal hernia of recent origin, which became inflamed, and after a few weeks opened and discharged blood, pus, and fecal matter. During the operation Schmidt found a hernia sac in which was caught a vermiform appendix—along the side of this a sound could be readily passed into the abdominal cavity.

The hernial sac was removed and its opening closed. Complete recovery. Close examination of the removed vermiform appendix disclosed the presence of a large black pin.

Personal Experience in the Operative Treatment of Ruptured Tubal Pregnancy.

(*Berlin Klin. Wochen.*, 1892.) Guaserow gives a report of twenty cases operated upon by him. In thirteen of these there had been no premonitory symptoms previous to the collapse brought on by internal hemorrhages, while in seven there had been a formation of an hematocoele previous to the dangerous hemorrhage which called for operation.

In the first group of thirteen there were two deaths. One due to collapse, the operator having been called too late. The

other died thirty days after from chronic disease of the kidneys.

In the second group of seven cases there was one death.

Gusserow advises, as a result of his experience, operation for all cases of ruptured tubal pregnancy. He would not hesitate to have a patient in collapse taken to the hospital for operation. Prognosis is always more favorable the earlier the cases are recognized and operated on.

In closing his remarks he expresses himself in favor of operation on such cases in

which the diagnosis is clear, previous to rupture, but adds that sure diagnoses are oftentimes difficult, since a small ovarian cystoma lying close to the uterus might be taken for tubal pregnancy. In such cases he advised placing the patient under careful and close observation, absolute rest and expectant treatment, in order to determine if the uterus or the tumor increases in size. It is of yet greater difficulty to determine whether the ovum in the tube still lives or not: a question which materially influences the operator in deciding upon prompt interference.

ABSTRACTS.

THE ADMINISTRATION OF CHLOROFORM, AND ITS DANGERS.

In an address before the Inter-colonial Medical Congress of Australasia, Dr. James Robertson, President of the Section in Medicine, says:

The vital importance of the subject, the frequent occurrence of fatalities, and the conclusions arrived at by the Hyderabad Chloroform Commission, which he regards as fraught with danger, induced him to select this subject.

The administration of chloroform—the most potent and valuable of anæsthetics—is to be regarded as one of the most responsible duties devolving on a medical man; seeing that the life of a human being is at stake, and its sudden termination is dependent, in a great measure, on his care and vigilant circumspection. Notwithstanding the numerous attestations in favor of chloroform, many in doubt and distrust are adopting the use of ether.

No anæsthetic can be said to be absolutely free from danger, but with judicious care and caution the risk may be reduced to a *minimum*. Chloroform has been well described by Dr. Lauder Brunton, as being “like a sharp knife in the hands of the surgeon, as compared with a blunt one. It is more efficient for good, if properly handled; it is more powerful for evil, if misused.” Ether, it must be allowed, is less dangerous than chloroform, in not causing so much depression of the heart's action, but it is unpleasant, irritating to the air-passages, cannot be used under certain circumstances or in every case.

Chloroform maintains supremacy as the most “pleasant, speedy, and efficient” anæsthetic, requiring no special apparatus, suitable in every case fit for operation, and safe when given with judicious care. Its advantages are such, that it has been generally adopted in preference to all other anæsthetics, and is still regarded with most favor.

In 1888, and again in 1889, Commissions were appointed by His Highness the Nizam of Hyderabad, at the request of Surgeon-Major Lawrie, to investigate the action of chloroform. The philanthropy of His Highness, in liberally supplying funds for the experiments, and the expenses of an expert sent from England, cannot be too highly appreciated, the laudable object of the commission being, in the words of the Nizam, “to save people's lives.” The commission, after the sacrifice of hecatombs of dogs and monkeys, arrived at the conclusions, that, “in every case where chloroform was pushed, the respiration stopped before the heart,” and that “the administrator should be guided as to the effect entirely by the respiration.” The numerous experiments and their record manifest careful and laborious investigation, and merit the thanks of the profession, but the conclusions arrived at cannot be accepted as applicable to human subjects. The result of the experiments has been to direct attention to a subject of vast importance, and to arouse inquiry, which cannot be otherwise than beneficial.

My experience of the administration of chloroform extends from the year of its introduction by Professor Simpson, 1847, the year in which I myself commenced practice. For nearly forty-five years I have exhibited that anæsthetic in many thousand cases, often in prolonged operations, and never with fatal consequences. I refrain from reducing the number to figures, as I cannot even give a close approximation to it. In not a few instances, alarming and even dangerous symptoms have presented themselves, and have strongly impressed me with the risk of trusting alone to respiration as the index of danger. I have watched both pulse and respiration, and ultimately came to regard the state of the pulse as the first signal of danger. I have no new experiments to lay before you, but I shall endeavor to demonstrate, from the experiments of others, and from clinical observation and experience, that the state of the pulse is not of less importance than the state of respiration, as an indication of danger in the administration of chloroform; that it is, indeed, the earliest and most significant danger signal.

Different individuals are differently affected by chloroform inhalation, and this may be accounted for by constitutional peculiarities. Some inhale quietly, and are speedily brought under its influence; some become excited, and toss their extremities about; while others resist and struggle violently. This, however, may be due to the mode of administration.

It is very generally urged, that the pulse should not be taken as any guide in the administration of chloroform; that the respiration alone demands attention. This contention seems to be strengthened by the Report of the Hyderabad Commission, to the effect that, in animals respiration always stopped before the heart, and that all danger can be averted by attending to the respiration alone. Although I do not decry the results of experiments on the lower animals, inasmuch as they afford most valuable indications, I object to hard and fast lines being drawn, and hesitate to accept the dictum, "that the effects of chloroform are identical in the lower animals and in the human subject." It is well known that the effects of various drugs differ much, more especially of narcotics, when administered to the lower animals and to man. The lower

animals are not capable of being influenced by the same feelings and emotions as man, and, according to the testimony of the Hyderabad Chloroform Commission, operations liable to produce shock and syncope in man, were singularly devoid of effect in dogs. The effects of chloroform are not uniform in different human individuals, even when administered in the same way, and in certain definite proportions, or even in the same individuals at different times. According to the experiments of the Hyderabad Chloroform Commission, respiration always fails before the circulation, and there is no such thing as chloroform syncope. Experiments on animals reported by other Commissions, "the Royal Medico-Chirurgical Society's Committee of Inquiry," and "the British Medical Association's Committee on Anæsthetics," negative to some extent the conclusions of the Hyderabad Chloroform Commission, showing that, while in most cases the respiration stopped before the heart, sometimes both respiration and the heart's action failed simultaneously, and sometimes the heart failed before respiration. The testimony of other observers is not less adverse. Dr. Snow, forty years ago, showed that, in animals killed by chloroform inhalation, when the air contained not more than 5 per cent. of vapor, the heart continued to pulsate when respiration had ceased. When the air contained 10 per cent. and upwards, death took place more speedily, respiration and circulation ceasing at the same time, there being sufficient vapor in the lungs at the moment the breathing stopped to paralyse the heart, as soon as it was absorbed and added to that already in the blood. This, he terms its cumulative property, when the effects of chloroform increase after discontinuance of inhalation.

It appears that the most immediate effect of chloroform on the heart, or on the respiration, was influenced by the more or less concentrated state in which it was administered. But, even were it proved that chloroform invariably causes death in animals by paralyzing the respiration, we have the most positive evidence that failure of the heart's action is the most frequent cause of death in man. An overwhelming amount of evidence has accumulated, and still continues to accumulate, since the first recorded death from chloroform in 1848, to the effect that the

occurrence of death in the human subject is almost invariably due to primary failure of the heart, or syncope. Such is, indeed, the principal source of danger, and it is a remarkable circumstance that a diversity of opinion should exist in regard to a question capable of definite solution.

Clinical experience goes to prove that death from failure of the heart is the usual source of danger in the human subject, and is especially liable to occur when the vapour of chloroform is inhaled in a concentrated form, or insufficiently diluted with air. The records of the numerous fatal cases reported in the various medical periodicals conclusively attest that death from syncope is the most common termination in man. For not only have the deaths been attributed to failure of the heart, but in cases where *post-mortem* examinations were made, such lesions have been described as "fatty heart," "flabby heart" "heart dilated," &c., &c. It is well known, however, that in many, if not in most, cases, where death has supervened, no lesion of heart, or of any other organ, has been discovered—that, in fact, the syncope was due to chloroform poisoning.

THE INDICATIONS AND SOURCES OF DANGER OF CHLOROFORM NARCOSIS.

The period of greatest danger appears to be at the commencement of inhalation, before the patient has been thoroughly brought under its influence, and not during the progress of even a prolonged operation. It has been stated that the danger of failure of the heart's action, from the depressing effect of chloroform, depends on, and is in proportion to the length of time of inhalation, and consequently of the operation. This, however, is not the case. If chloroform is given sufficiently diluted with fresh air, and respiration continues normal, the vapour of chloroform is exhaled, as well as inhaled, and the blood does not become so saturated, as to endanger the heart. The danger is, in a great measure, dependent on the amount or degree of concentration of the vapour inhaled; as the vapour, if inhaled insufficiently diluted with air, affects the heart more directly, and may lead to sudden paralysis of that organ.

The immediate causes of death in chloroform toxæmia, are syncope, and apnoea. In the large majority of cases, death takes place from sudden syncope in

the human subject, due to paralysis of the heart.

Death may also result from syncope brought about by the combined effects of sickness of stomach, and the depressing influence of chloroform on the heart. This stomach sickness, or nausea, has been stated "to be only unpleasant and inconvenient, desirable to avoid, but not attended with any danger." It has, however, proved a real danger, inasmuch as in not a few cases, suffocation has been induced by food being drawn into the glottis during the effort of vomiting. But apart from this, when there is no food in the stomach, there is, in my opinion, a real danger attending sickness, unless the pulse is watched. I have frequently observed the pulse became slow and weak, and the lips blanched, and have thus been led to withdraw the chloroform instantly, and then the faintness was followed by vomiting. If, instead of withdrawing it, chloroform had been pressed, as I have somewhere seen advocated "to stop the contractions of the stomach," it might have resulted in stoppage of the heart's action. I am strongly of opinion that, when a patient is in a fainting condition, even a small dose of chloroform may so affect the heart, as to cause complete cessation of its action, and that the pulse gives the first indication of danger, the first warning, respiration if at all, being but little influenced.

Deaths from apnoea are only occasionally met with. They arise from spasms of the glottis and diaphragm obstructing the respiration, and are sometimes attributed to reflex action in some operations (ligaturing hemorrhoids, etc.), when the patient is not thoroughly anæsthetised. Apnoea is sometimes attributed to the tongue falling back and occluding the glottis, when a patient is lying on the back under the influence of chloroform narcosis; from this source, I have never seen any cause for alarm.

PRECAUTIONS TO BE OBSERVED IN ADMINISTERING CHLOROFORM.

It will be readily admitted that the chloroformist should give his whole attention to his patient; should see that the chloroform is pure; that the patient has not recently eaten food; that he is placed in the recumbent position, or in such a position as not to obstruct respiration, all

articles of clothing being loose about the neck, chest, and abdomen. I regard the use of table-napkin or towel folded in the form of a cone, with or without an aperture at the apex, such as was originally proposed by Professor Simpson, as well adapted for the purpose. One-half to a drachm of chloroform should be sprinkled on the napkin as required, so as not to moisten the border likely to come in contact with the face.

In commencing inhalation, always allow sufficient space for the free admission of atmospheric air, so that the vapour may be diluted, and its effect may be gradually produced, so as to avoid exciting cough or struggling. Allowance should be made in the warm season of the year for the effect of temperature in rendering chloroform more volatile, and thus causing the air to become more saturated with the vapour. Patients should be gradually brought under the influence of chloroform until its full effect is produced, and then very little chloroform will be required to maintain insensibility. The vapour may be diluted with more air, by withdrawing the inhaler to some extent, or inhalation may be intermitted for two or three inspirations occasionally.

The state of the pulse should be carefully watched; it gives the first indications of danger. When the pulse becomes weak and slow, perhaps irregular and intermittent, fresh air should be freely admitted; when, moreover, respiration becomes shallow and feeble, perhaps stertorous, the inhaler should be withdrawn altogether for a short time. In prolonged operations, special care should be taken that the vapour inspired is sufficiently diluted with fresh air, so as to guard against sudden syncope, the most frequent cause of a fatal termination in the human subject.

MEASURES TO BE ADOPTED IN SUSPENDED ANIMATION FROM CHLOROFORM.

The head should be lowered and feet elevated, and artificial respiration commenced without delay, fresh air being freely admitted, and any obstruction to respiration removed. Nelaton's plan of inverting the body, and artificial respiration, are without doubt most conducive to resuscitation in chloroform poisoning. By this means the blood will gravitate towards the head, and the action of the heart may be roused to contract, and send a supply

of blood to the brain and medulla, so as to stimulate the cardiac and respiratory centres.

No successful issue has followed the employment of galvanism that I have heard of; and certainly, not more benefit can be expected to result from nitrite of amyl inhalation, which causes dilatation of the peripheral blood-vessels, a condition already existing to the fullest extent, and which it is desired to remedy. Nitrite of amyl is therefore contra-indicated. The injection of ether subcutaneously, or of ether and strychnine, is more rational, and likely to prove of benefit, artificial respiration being kept up. Mr. Bader (Ophthalmic Surgeon, Guy's Hospital) states that, "out of a large number of cases (3224), some presented serious symptoms, becoming blue in the face, with stertorous breathing and irregular pulse, seven became pale suddenly, with respiration and pulse stopping. In all these cases the chloroform was removed, and the patient slowly and gently turned to the left side. Patients recover rapidly when placed on the left side, due, it may be, to the support given to the heart, or to a change in the position of the tongue." This, he states, is the sole means adopted at Guy's for the last six years.

The Marshall Hall method failing to restore animation in a desperate case, Dr. Prince, (Illinois State Medical Society, 1891,) adopted a new method of resuscitation based on Nelaton's method of inverting the body:—He seized the patient, a boy of 14 years, by the ankles, his knees being flexed over the doctor's shoulders, with head and arms dangling toward to floor. In that position he subjected him to "double-quick motion around the operating-room, and after about three minutes, the sounds of restored respiration were heard." The doctor further states:—"Each step was taken with a springy motion, by which the weight of the intestines resting upon the diaphragm would be alternately applied and removed with the tread, the effect of which would be calculated to stimulate the heart and force the blood along its channels, while the air was simultaneously changed in the lungs." Three other cases are related, one a young woman of great weight (140 lb.), another a physician, who were subjected to similar treatment with alike favorable results. As it appears that in

two of the four cases reported, the Marshall Hall method of restoring animation was had recourse to, without success, before adopting the method described, the success of the new method appears to be the more remarkable, seeing a considerable time (not noted) was said to have elapsed before it was commenced. That fact caused me to hesitate in crediting the report, but the circumstantiality in detail, the names and dates, etc., forbade my en-

tertaining any doubt of its genuineness.

From the preceding remarks, it will be apparent, that, in my opinion, chloroform is the best anæsthetic yet discovered; that it is quite safe if judiciously administered, and its action closely watched; that the pulse, and not the respiration, gives the first indication of danger, and ought, therefore, not only to be constantly under the fingers, but to occupy the attention. —*Australian Med. Jour.*

APPENDICITIS:—MEDICAL AND SURGICAL MANAGEMENT.

At the September meeting of the Missouri Valley Medical Society, Dr. A. F. Jonas, read a most interesting paper on the above subject. Notwithstanding the fact that the topic is almost worn threadbare, it is one of such importance that the physician should be alive to the necessity of being ever ready to meet it, especially does this apply to those physicians practicing in rural districts where they do not have time nor opportunity to call counsel.

While surgery is making such rapid strides followed by most brilliant results; he advises the younger practitioners not to be carried away with the idea that medicinal means are of no avail, in the treatment of appendicitis, but urges a more thorough study of the disease, and accuracy in diagnosis. Good sound judgment and anatomical knowledge of the parts are absolutely necessary, before the physician can be sure of just when to call surgery to his aid.

He gives a table of a series of thirty cases, which have occurred in his practice, or have come under his notice. The treatment was largely surgical; a few cases apparently recovered under medicinal measures. After carefully considering the various means, usually employed in the treatment of appendicitis he summarizes as follows:

1. When called early, insist on absolute rest in bed.

2. Fomentations, if pain is severe, and give codeine if necessary.

3. Salines (liberal doses) every half hour until four to six fluid stools are produced.

4. If the salines, after having produced free catharsis, fail to relieve, or aggravate the pain and fever; *operate*.

5. If salines fail to produce free catharsis; *operate*.

6. Temporizing with salines, or any other form of medicinal treatment, is worse than useless. When there is the slightest evidence of the presence of pus, an operation must be done at the earliest possible moment.

7. Guard against over-zealousness in search of the appendix, in large abscess cavities, lest the limiting intestinal agglutination be broken down and general peritoneal infection follows.

8. Always remove the appendix when it can be safely done.

9. Elevate the pelvis, as in Trendelenburg's position, in cases of small abscess limited to the lumen of the appendix or its mesenterium, or in any case when the peritoneal cavity is entered and where the intestinal distention is such as to make it difficult to find the caput-coli, or the appendix.

WHY SHOULD I NOT USE THE FORCEPS?

This is the title of a highly interesting paper, read before the Topeka Medical Society, by Dr. M. R. Mitchell.

After giving a brief history of the for-

ceps, mentioning the principal objections to their use as well as the advantages, he concludes that three questions present themselves, viz.: "How can they be suc-

cessfully and advantageously used?"

"When should they be used?"

"Why should they be used?"

In answer to the first query, he says the main points are accurate diagnosis; thorough knowledge of the mechanism of labor; perfect cleanliness; gentleness and a cool steady hand. Every physician should possess reliable instruments and accustom himself to their use.

The indication for their employment is a matter of judgment, and the individual case.

Before resorting to the forceps the accoucheur should have ready all necessary medicine and appliances, in case of danger

to the child, or hemorrhage following. Coolness and decision should characterize his movements under all circumstances. He thinks that those who condemn their use and portray tales of woe and bloody work of the instrument, have entirely misjudged their proper and judicious use; that where properly and skillfully applied they do not cause laceration of the perineum that would occur in normal labor.

He declares that many mothers' lives might have been saved; and there would be fewer still-born children if physicians did not so closely adhere to that adage, "Meddlesome mid-wifery is always mischievous."

A CASE OF ALBUMINURIA DURING PREGNANCY.

In a paper read before the Obstetrical Society of Cincinnati, (*Med. Progress*), Dr. C. D. Palmer gave the history of a case of a patient who he found had considerable swelling of face and albuminous urine.

Fearing puerperal convulsions, he placed her on saline treatment and then deemed it best to induce labor.

Improvement began, and the albumen diminished. On fourth day after delivery, however, she began to have difficulty of breathing. On examination he found that she had a commencing pneumonia. She was placed under the influence of carbonate of ammonia and small doses of morphia. Next day finding an irregular dicrotic pulse of 140 to 150, he gave her hypoder-

mically two drops of a one per cent. solution of nitro-glycerine.

Immediate improvement followed, this dose was repeated three times daily, for a while and then given by the mouth.

The urine became less albuminous and breathing less laborious; at the end of a month the patient was discharged.

While nitro-glycerine has no direct action on the heart, it has a most potent influence, indirectly. It will increase the secretion of urine by directing the blood from the kidneys, in Bright's disease, to the outside of the body.

This is the third case of this kind, in which Dr. Palmer has used nitro-glycerine with the same pleasing results.

PLACENTA PRAEVIEW.

Dr. R. S. Kelso read a very interesting and practical paper before the South-west Medical Society at West Plains, Mo., (*Kansas City, Med., Index*) on the above subject. He prefaces his article, by giving the history, symptoms and pathology of the trouble, and urges more thorough study and preparation to meet the emergency.

The treatment varies: the general rule holds good, that what is best for the mother, is best for the child, i. e., speedy delivery.

Slight hemorrhages, require nothing further than close watching and rest in bed.

When hemorrhage is severe, or oft repeated, delivery should be hastened.

If the os is but slightly dilated, tampons may be used,—being left in for twenty-four to thirty-six hours. Then on removal if dilatation has occurred sufficiently, grasp the presenting part or turn and deliver. Strict antisepsis should always be observed.

The situation is one of such gravity that the physician should not loose his head. A steady nerve and knowledge of what to do at the right time, will help him in many trying moments.

Veratrine Viride in Scarlet Fever.

In the *Columbus Medical Journal* Dr. R. E. Chambers gives his practical experience of over thirty years, in the use of this remedy. He claims that it has always given him good results, and that when called to a case of scarlet fever, he has a remedy that will not disappoint him in cases free from such complications as failure of the kidneys to secrete, pulmonary edema, etc. Furthermore, these complications will not occur if the case is seen and treatment begun early. As proof of the usefulness of the drug in this disease, he cites an instance in which he was called to a family of eight children, all ill with a severe type of scarlet fever,—circulation rapid, fever high, throats intensely swollen and offensive. Giving a most unfavorable prognosis, he began giving Norwood's tincture of veratrum viride with nitric ether; using one drop of the veratrum for each year of age of child, with three times the amount of ether. This medication was continued every hour, until vomiting was produced; then discontinued until fever should be manifest, then every three hours until vomiting should occur again. A solution of Chlorate of Potash was used in their throats, also free sponging externally. This treatment was followed out and in a few days the cases were convalescent.

He considers the drug a safe and sure remedy in the treatment of scarlet fever even claiming that some cases be aborted by its timely use.

Specific Urethritis in Children.

Dr. John A. Weyeth, in a clinical lecture, said that gonorrhœa in young children is comparatively rare. Reference to works on diseases of children fail to show anything on this subject, and standard authorities on genito-urinary diseases mention but few isolated cases.

He is of the opinion that there are many cases that escape observation, or are treated for something else.

The principles of treatment do not differ from those which govern specific urethritis in an adult. The principle interest centres in the diagnosis, which must be accurately made in every suspicious case.

Emergencies.

ACCIDENTS IN GIVING ANÆSTHETICS.—Tincture of digitalis hypodermically; draw out the tongue and see that respiration is not mechanically impeded; invert the patient quickly and temporarily; use forced respiration promptly; apply external warmth and stimulation; avoid the exhibition of alcohol.

ANGINA PECTORIS.—Inhalation of chloroform, or a few drops of nitrate of amyl; 1-100 grain of nitro glycerine, internally; placing the feet in hot water; mustard to the precordial region; dry cup between the shoulders; hypodermic injections of morphine and atropine; administration of stimulants and anodynes.

APOPLEXY.—Elevate the head and shoulders; if pulse is moderately strong and the brain congested, bleed from the arm freely, sixteen ounces or more; electerine (one-sixth grain) or croton oil, two drops in a drachm of sweet oil or glycerine; cold to the head by means of an ice bag.

ASPHYXIA.—In drowning, hold the patient's head downward for a few seconds. In hanging or choking, bleed from the jugular. If there is obstruction to passage of air through the mouth or nose, open trachea. Artificial respiration at once, and to be continued. Friction, warmth, warm bath (100°) ammonia to nostrils, galvanizing of phrenic nerve.

ASTHMA, SPASMODIC.—Hypodermic of atropine into the nape of the neck; inhalation of smoke of stramonium leaves; fluid extract of nux vomica, internally, alcohol, ether, chloral, opium; inhalation of chloroform cautiously administered.

COLIC, GALL.—Morphine, hypodermically; inhalation of chloroform; hot applications to the abdomen.

COMA.—Dark room; head high and cool; head shaved; low diet; croton oil; if due to compression, antiseptic trephining; if due to anæmia, pilocarpine and hot baths.

HEAT STROKE.—Remove clothing, sprinkle with water, cold cloths to the head, hot cloths to the feet; antipyrin; bleeding in robust subjects. After temperature is reduced give alcohol and diffusible stimulants, hypodermically if necessary.

HICCUGH.—Acid drinks, cold douches, ether or chloroform internally, externally or by inhalation; musk, opium, antispasmodics.

CURRENT LITERATURE REVIEWED.

THE AMERICAN JOURNAL OF OBSTETRICS

For January contains two articles on

Ectopic Gestation.

The paper by Dr. James W. Ross, of Toronto, Canada, is a scholarly article, well worth the attention of the practitioner, whether he be an abdominal surgeon or no. In his classification of the different varieties of this accident, Dr. Ross follows Tait and Parry closely. He thinks that ovarian pregnancies are as yet not proven and, while stranger things have happened, the proofs adduced do not seem to him convincing. Of the causes of extra-uterine foetation, he considers gonorrhoea the most frequent; acting, as it does, by destroying the ciliated epithelium of the tube and preventing the passage of the ovum into the uterus. The symptoms are minutely discussed and stress is laid on a period of sterility followed by a supposed abortion. Should such a patient present herself with a pelvic mass and elevated temperature, she should be closely questioned as to the supposed abortion, as such, he says, are frequently cases of ruptured ectopic gestation. As to the diagnosis of extra-uterine pregnancy before rupture, he says, "no man can be positive of his diagnosis of intrapelvic disease until it is confirmed by abdominal operation." The assertion is a sweeping one, yet we believe it to be true in the main. In regard to the treatment, he thinks that there is but one—the knife. Of electricity, he remarks that there is, as the Yankee said, "nothing to it." The argument for and against electricity is discussed in the same masterly manner that characterizes the whole paper. The article closes with a table of extra-uterine operations.

The second paper on "Extra-uterine Gestation,"* from the pen of Dr. Edwin B. Cragin, of New York, deals with the subject purely from the operative point of view and is an account of the operations the author has performed, with the history of the cases. The article is illustrated with several photographs of the specimens. In his views on the diagnosis and treatment, he coincides with Dr. Ross.

Dr. W. W. Jaggard, Chicago, contributes a

Note on one of the Conditions of the Use of
Electricity in the Treatment of Uterine
Fibroids.

Electricity was applied in a case of multiple fibromata, in accordance with Apostoli's method, with the result that the tumor became perceptibly harder and the oozing of blood ceased. After two or three applications the patient developed a fatal septic peritonitis and at the post-mortem the peritoneal cavity contained serum, flakes of lymph, and two tablespoonfuls of pus. The tubes presented signs of catarrhal salpingitis, but contained no pus. The case goes on record as a death following the use of electricity for fibroids; whether the fatal result was due to the agent used or not. Again, it confirms

the observation often made that disease of the adnexa is present in nine out of ten fibroids, as shown in those removed by hysterectomy. Since Apostoli has pointed out that tubal disease is a contra-indication to the use of electricity, it would seem as if the number of fibromata suited to his treatment is very limited.

Ventral Hernia Following Laparotomy

Is the title of a paper by Dr. L. H. Dunning, of Indianapolis. The various causes of this accident are well shown, such as the prolonged use of the drainage tube, constipation, and a lack of tonicity of the tissues. The prevention of the trouble lies in the careful approximation of the divided structures, with avoidance of the other conditions that lead to hernia. The abdominal binder is recommended to be worn for at least a year after operation. The operations for the relief of the hernia are clearly described.

Dr. Samuel L. Weber, of Chicago, contributes

A Prompt and Radical Cure of Mammary
Abscess by a New Method of After
Treatment.

He treats the abscess by an incision in a line radiating towards the nipple and a thorough curetting of the abscess cavity, followed by a douche to wash out all debris. The cavity is then packed with strips of gauze soaked in a one per cent. carbolic solution; the packing being renewed every twenty-four hours. After two or three days of such packing the cavity will be found healthy and filling up with granulations. The packing is now stopped and the wound covered with a thin layer of gauze over which a large flat sponge is placed, covered with a piece of oiled silk, and held in place by a firm bandage; the idea being to make as firm compression as possible. To aid in this compression, the sponge is soaked, after the bandage is in place, with the carbolic solution. The breast should be compressed flat against the chest and not in the pendant position. The author claims that, by this method, the duration of treatment is very much shortened. The new part of the treatment claimed consists in the firm compression. Neither principle nor method are new.

Dr. J. G. Clark, of Baltimore, reports a "Cystoma Ovarii Glandulare Associated with Hydrops Polliculi." The article is illustrated with three cuts of the tumor, which was removed at the Johns Hoskins Hospital.

Dr. W. D. Porter contributes a paper on the

Management of the Third Stage of Labor.

His plan is a slight modification of the well known Crede method. As soon as the child is born the uterus is grasped with both hands, but no compression is made until one or two pains have occurred. With each pain compression is made, but not with enough force to make the woman complain. When the placenta is felt to have slipped into the vagina an antiseptic finger is passed into the vagina and hooked into the placenta, pulling it

* "Operative Experience with Ectopic Gestation."

gently out, while the other hand makes pressure on the uterus from above. The procedure would seem to have no special advantage over the older method.

Dr. W. W. Jaggard reports a case of "Thorapagus." The monster was composed of two relatively equal female forms, disposed face to face, and confluent at the anterior aspect of the thorax and abdomen. Labor lasted about eight hours, one and one-half hours being consumed in the extraction which required considerable force. Patient recovered.

Dr. S. Marx, of New York, reports a "Case of Accidental Hemorrhage During Labor." Dr. Mary Almira Smith reports a successful case of "Porro-Cæsarean Section," which was performed for a deformed pelvis, rendering natural birth impossible.

This number concludes with a memorial notice of the late Professor A. Reeves Jackson.

THE THERAPEUTIC GAZETTE.

The two more important articles of the December issue of the *Therapeutic Gazette* are "The Surgical Treatment of Appendicitis and its Limits" by Dr. W. E. Ashton and "The Medical Treatment of Appendicitis and its Limitations" by Dr. James Graham. These two articles were the subject for discussion at the Clinical Meeting of the Alumni of the Jefferson Medical College. Dr. Stark offers a paper, "The Creasote Treatment of Tuberculosis." These observations are based on a personal analysis of numerous cases. Dr. Kelly's "Treatment of Pneumonitis with Digitalis" will be read with some interest.

THE PRACTITIONER.

The *Practitioner* comes to us for December with three articles. The most important of these is "The Dietetic and Medicinal Treatment of Rheumatoid Arthritis" by Dr. John K. Spender.

THE GLASGOW MEDICAL JOURNAL.

Dr. Buchanan's paper,

A Case of Puerperal Fever, Illustrating the Mode of Infection and the Infective Agent,

says, in discussing the source of the infective agent, that there is a deep-rooted belief that this is conveyed in most cases to the patient; and no doubt it is very often transmitted from other cases of puerperal fever, but it is probable that in a considerable number of cases the patient herself is the source of the infection. For the streptococcus pyogenes, which is always present in these cases, may be cultivated from mucous surfaces apparently healthy. He, therefore, believes that this microbe is present in the vagina before labor. It may be introduced into the uterus before or after labor. Moreover, he further states, there is a possibility of infection from an "old unilateral salpingitis." Mr. John McGregor's article "The Epidemic of Cholera in Paris" and three

small papers read before the *Glasgow Pathological Society* complete the December issue.

EDINBURGH MEDICAL JOURNAL.

In December's number Mr. Milton offers a "few words" about the pathology and treatment of "Lupus"—before the tale is told quite a lengthy article appears. Dr. A. G. Miller's paper,

Excision or Arthrectomy of the Knee Joint,

states that by the terms excision and arthrectomy is meant that operation, exclusive of amputation, by which all the diseased tissues are removed, with the best possible results to the patient in the shape of a useful limb. He says that experience has taught him that, to get a satisfactory result in strumous joints, it is necessary to remove the whole of the diseased synovial membrane. His method in operating is, after reflecting a semilunar flap of skin well above the patella, to cut through the tendon of the extensor of the thigh a little above the patella, and also through the fibres of the vasti, internal and external. In this way the synovial membrane is exposed. It is then easy to push up the muscular substance, draw down the thickened synovial membrane, which comes off the periosteum readily, and then to cut at its attachment round the articular surface of the femur. In this way four-fifths, or thereabouts, of the synovial membrane is removed in one mass with the patella imbedded in it. Those portions of the membrane that cover the ligaments are then removed by the use of the Lister sharp spoon. The ligaments should be scraped till they appear clean and white. They are then cut through to permit of complete flexion of the joint, and the operation is completed by the removal of a sufficient amount of bone. There seems to be one fact further to consider in the review of this paper, and that is, the removal of the patella, which, he states, is not an object of his operation, but is a necessary part, for it comes away in the centre of the synovial mass. He does not consider the removal of the patella a disadvantage; because (1), it is often diseased; and, (2), if the resulting limb be thoroughly ankylosed and rigid the function of the patella is gone, and the straight limb looks neater without it.

"Some Practical Results of the Investigation of Cholera in Germany," by Dr. William Russell completes the list of communications of any merit.

THE DUBLIN JOURNAL OF MEDICAL SCIENCE.

Of the five papers offered in the December number possibly the most important one is an address by Dr. Hamilton, President of the Section on Surgery in the Royal Academy of Medicine in Ireland, on "The Surgery of To-day." He gives an exceedingly interesting and instructive account of the growth of surgery from the time when bleeders, cuppers, and leechers were in vogue to the placing of surgery on a tripod of three solid and enduring feet—anæsthetics, antiseptics and experimental research.

SELECTED FORMULÆ.

Emulsion Castor Oil.

- R** Castor oil..... 1 oz.
 Syrup rhabarb..... 4 drachms.
 Alcohol..... 4 drachms.
 Essence peppermint..... 2 drops.
 Mix, and shake well together. The taste of the oil is completely disguised.

—Phar. Era.

Liniment for Neuralgia.

- R** Chloroform..... 3vi.
 Sulphuric ether..... 3i.
 Spirits camphor..... 3iii.
 Tinct. opium..... 3iss.
 M. Sig.—Soak a small piece of flannel with the liniment, and apply over the painful part.

—The Doctor.

To Clean Cistern Water.

Add two ounces of powdered alum and two ounces of borax to a twenty-barrel cistern of rain water that is blackened or oily, and in a few hours the sediment will settle, and the water will be clarified and fit for washing.

—Tex. Health Jour.

Serous Diarrhœa.

- R** Pulv. opi..... gr. i.
 Plumbi acetat..... gr. ii.
 Camphore..... gr. i.
 M. ft. Pil. no. 1.

—H. A. Hare.

For Removing Warts.

A most successful means of removing the ordinary wart, whether situated on the hands or elsewhere, is as follows:

- R** Acid salicylici..... g. xxx.
 Ungt. aque rose..... 1 ss.

M. S. Apply twice daily for two days, after which the growths being softened, they should be removed by a dermal curette, and by using these means you can safely say that the wart will not return.

—J. Abbott Cantrell.

For Small Hemorrhoids and Pruritus Ani.

- R** Hydrarg. chlo. mitis..... gr. xx.
 Cocaine muriat..... gr. x.
 Petrolati..... 3i
 M. ft. ung.
 Sig. Apply as directed.

An Ointment for Hemorrhoids.

- R** Hydrochlorate of cocaine..... gr. xviii.
 Sulphate of morphine..... gr. iv.
 Sulphate of atropine..... gr. iv.
 Tannic acid..... gr. xviii.
 Vaseline..... 3i.

This ointment is to be applied to the hemorrhoids.

—L' Union Med.

Tape Worm.

Treatment.—Fast patient eighteen hours, and purge during the time. Then give hourly, wineglass doses of pomegranate decoction, made as follows:

- R** Fresh Pomegranate Bark..... 2 ounces.
 Aque Puræ..... 2 pints.

Boil down to one pint, strain and use.

It is necessary to get the head in order to establish a permanent cure.

—The Doctor.

For Frost Bite.

- R** Ol. lavandulæ.....
 Acid. carbolic..... 3ss.
 Olei oliv..... 3ss.
 Unguent. plumbi..... 3ss.
 Lanolin..... 3ss.
 Ft. ung. Sig.—Apply topically.

—Lassar, Med. News.

Habitual Constipation.

- R** Extract physostigmatis.....
 Extract belladonnæ..... 3ss.
 Extract nucis vomical..... 3ss.
 Aloin..... gr. ½.
 M. ft. Pil.

—Prof. R. Bartholow.

Coccydynia.

Whitla recommends the following suppository employed at bed-time.

- R** Ext. belladonnæ..... ¼ grain.
 Ext. hyocyami..... ¼ grain.
 Iodoform..... ¼ grain.
 Ol. theobromæ..... 20 grains.

Nervous Cough.

- R** Acidi Hydrocyanic Dil..... 1 drachm.
 Tinct. Sanguinariae..... ½ ounce.
 Syr. Senegae..... 4 drachms.
 Aquae Lauro-cerasi..... 7 drachms.
 Spr. Tolu..... 2 ounces.

M. Sig. From ten drops to a teaspoonful every four hours, according to the age of the patient.

—The Doctor.

Painless Dilatation of the Cervix Uteri.

For this purpose, Le Fort recommends:

- R** Iodoform..... 3iii.
 Powdered cocaine..... gr. lxxx.
 Sulphuric ether..... 3iii.

Make a solution, and wet a laminaria tent with the same. This may then be introduced into the uterine canal, and dilatation obtained without causing pain.

—L' Union Med.

Detection of Pus in the Urine.

Drop into the specimen of urine enough tincture of guaiac to give it a milky appearance, and heat it a few minutes to 100°F. If pus is present a blue tint will develop. Otherwise, the urine may be passed through a white filter, on which is then allowed to fall a few drops of tincture of guaiac, producing, if pus is present, a distinct blue discoloration.

—Ex.

Treatment of Gonorrhœa.

Dr. W. J. James, of Cleveland, Ohio, has employed the following injection with excellent results in the treatment of a case of chronic gonorrhœa, where solutions of sulphate of zinc, nitrate of silver and bichloride of mercury proved inefficient, and he has derived equal benefit from it in acute cases.

- R** Boracic acid..... 3iss.
 Tincture of iodine..... 3ii.
 Glycerine..... 3i.
 Distilled water q. s. ad..... 3iv.

M. Sig. To be used as an injection every morning and night.

He would like other physicians to give this formula a trial.—Med Bull.

Solution for the Treatment of Chancres.

DU CASTEL is stated to use the following solution in the treatment of chancre, by *L'Union Medicale*.

R Carbolic acid..... gr. xv.
Alcohol (90 per cent.)..... 5iiss.
Make a solution, and with a small pledget of cotton or wool touch the surface of the chancre. A light touch is generally sufficient. Cicatrization usually readily ensues.

—*Ther. Gaz.*

Catarrh, Acute Nasal, with profuse watery Secretion.

R Tinct. Aconiti Radicis..... 5ss.
Tinct. Belladonnae..... 5iij.
Tinct. Apii deodoratae..... 5iv.
M. Sig.—10 to 12 drops in water every three or four hours.

—*W. H. Bricker.*

For Asthma.

Bartholow recommends:—

R Potassii iodide..... 5ij.
Ext. belladonnae fluid..... f 5j.
Ext. lobeliae fluid..... f 5ij.
Ext. grindeliae fluid..... f 5ss.
Glycerini..... f 5ij. M.
Sig.—A teaspoonful as required.

Transfusion Fluids.

The following are given in the *Prescription*:

1. *Bilroth's*.
R Sodium phosphate..... gr. iij.
Sodium carbonate..... 5ss.
Ammonium carbonate..... 5ss.
Sodium chloride..... 5j.
Alcohol..... mclx.
Dist. water..... q. s. ad 5xx.

2. *Little's*.
R Sodium phosphate..... gr. iij.
Potassium chloride..... gr. vj.
Sodium carbonate..... 5j.
Sodium chloride..... 5j.
Dist. water..... q. s. ad 5xx.

3. *Walter's*.
R Sodium bicarbonate..... 5ss.
Calcium chloride..... 5ss.
Potassium chloride..... 5ss.
Sodium chloride..... 5j.
Distilled water..... q. s. ad 5vij.

M. For use, dilute 1 fl. oz. of this solution with water at 120°F., so as to make 16 fl. oz.

Dr. Stark, *Therapeutic Gazette*, in concluding his paper on "The Creasote Treatment of Tuberculosis," submits the following resume:

First.—Creasote is no longer an innovation or a fad, but a drug which has come to stay as an antitubercular remedy.

Second.—Creasote is particularly valuable in the earlier stages of tuberculosis.

Third.—Its administration must be in moderate doses for a prolonged period.

Fourth.—That it is a safe and reliable prophylactic in the condition that is usually described as pretubercular anemia.

Fifth.—It should be administered in combination with approved adjuvant remedies.

There are several easy and palatable methods of administration. The following prescriptions are ordinarily employed by me, the daily doses being dissolved in some alcoholic or vinous mixture, as whiskey or sherry wine.

R Creosoti (beechwood)..... mxlv.
Glycerini..... 5i.
Aque destil..... ad 5ii.
Dose.—5i t. i. d.

R Creosoti (beechwood)..... 5i.
Tinct. gentian comp..... 5ii.
Dose.—mxv t. i. d.

R Creosoti (beechwood)..... 5ss;
Bismuthi subnitrat..... 5i.
M. et f. in capsul. no. xv.
Dose.—One every four hours.

"Which side should I sleep on, doctor?" he inquired. "In winter or summer?" asked the doctor, rubbing his chin thoughtfully. "What's that got to do with it?" exclaimed the patient, half angrily. "A great deal," responded the doctor, mysteriously. "I don't see it." "Of course you don't," said the imperturbable; "if you did you wouldn't be here asking me questions about it." "Go ahead, then," said the patient, sitting back resignedly. "Well," continued the doctor, "in winter, when it is cold, you should sleep on the inside; but in such weather as this you should sleep on the outside, in a hammock with a draught all round it, and a piece of ice for a pillow. Two dollars, please."—*Med. Record*.

Man, born of woman, is of few days and no teeth. And indeed it would be money in his pocket sometimes if he had less of either. As for his days, he wasteth one-third of them. And as for his teeth, he has convulsions when he cuts them. And as the last one comes through, lo! the dentist is twirling the first one out; and the last end of that man's jaw is worse than the first, being full of porcelain and a roof-plate built to hold blackberry seeds. —*Burdette*.

Polite Doctor (cautiously)—"Your husband is suffering from overwork or excessive indulgence in alcoholic stimulants—it is, ahem! a little difficult to tell which."

Anxious wife—"Oh, its overwork! Why, he can't even go to the theatre without rushing out half a dozen times to see his business partners."—*Judge*.

PERISCOPE.

MEDICINE.

Tendon Reflexes.

The following classification of tendon reflexes by Dr. William C. Krauss (Buffalo Med. and Surg. Jour.) will be found useful:

Exaggeration of Tendon Reflexes.	Organic Disease.	Spinal Cord.	1. Myelitis 2. Amyotrophic lateral sclerosis. 3. Paraplegia spastica. 4. Multiple sclerosis. 5. Syringomyelia and hydromyelia. 6. Hematomyelia and hematomorrhaxis. 7. Spinal tumors. 8. Pachymeningitis hemorrhagica interna. 9. Pachymeningitis cervicalis hypertrophica. 10. Brown-Sequard's spinal paralysis. 11. Arthritic muscular atrophies.
		Brain.	1. Hemiplegia. { Cerebral apoplexy. Cerebral embolism thrombosis. Acute encephalitis 2. Hematoma. 3. Hydrocephalus 4. Senile dementia.
	Functional Disease.		1. Hysteria. 2. Epilepsy. 3. Neurasthenia. 4. Paramyoclonus. 5. Tetanus. 6. Psychoses. 7. Infectious processes.

Abolition of Tendon Reflexes.	1. Neuritis. 2. Locomotor ataxia. 3. Poliomyelitis anterior. 4. Spinal muscular atrophies. 5. Hereditary ataxia (Friedreich.) 6. Chorea mollis. 7. Chronic ergotism. 8. Diabetes mellitus. 9. Traumatism.	Simple. Toxic. Endemic. Infective.
Abolition and Exaggeration.	1. Meningitis. 2. Hementia paralytica. 3. Idiocy.	Spinal. Cerebral.

Congenital Syphilis.

Erlenmeyer (*Zeitschrift f. klin. Medicin*, xxi, 3 u. 4, p. 343) has reported seven interesting cases of congenital syphilis which he has studied in their relations to certain diseases of the nervous system. He expresses the view that late forms of congenital syphilis, so-called syphilis hereditaria tarda, may appear later than the twelfth year—that is hereditary syphilis may remain latent more than twelve years. Puberty, traumatism, and febrile affections may afford the necessary stimulation to arouse into activity a latent congenital syphilis. The law of Colles, that the mothers of children congenitally syphilitic through the fathers, is not without its limitations. Mothers that have given birth to congenitally syphilitic children may become syphilitic, though not necessarily. Immunity to syphilis is not identical with infection with syphilis. The law of Kassowitz as to the spontaneous gradual attenuation of the intensity of the syphilitic hereditary transmission is not absolute. Children born late may be infected in more intense degree than those born previously. Hereditary syphilis may alternate with the sexes; thus, if after the birth of a congenitally syphilitic child a non-syphilitic child of different sex is born, it is not proved that the capability of hereditary transmission through the father is exhausted. In arriving at a conclusion all the children must be considered. Anti-syphilitic treatment of the parents exerts a most favorable influence upon subsequent children. A form of cerebral disease development characterized by unilateral convulsions and lack of development is most commonly of syphilitic origin. The so-called cerebral paralysis of children and congenital epilepsy, with or without idiocy, are frequently dependent upon congenital syphilis. —*Med. News.*

Right Hemiplegia and Aphasia Following Diphtheria in a Child.

Allen A. Jones, M. D., Lecturer on Practice of Medicine and Instructor in Practice, Medical Department University of Buffalo, contributes the following to the *Medical News*:

In May, 1891, I attended Florence T., eight years old, during a severe attack of diphtheria. The local and constitutional manifestations of the disease were pronounced, but the patient passed safely through the severe stages, and in about ten days was free from pyrexia, had a clean throat and a good pulse. The child seemed so well that I ceased making daily visits. One morning, however, I was hurriedly called, and found her with complete right-sided hemiplegia and ataxic aphasia. The right side of her face was entirely paralyzed. Her mother informed me that the child was talking and laughing an hour before I was summoned.

She was not unconscious at any time. The usual evidences of pharyngeal paralysis existed. No cardiac bruit was detected. The patient's mentality seemed sluggish for a few hours subsequently to the attack, but thereafter was normal.

Her repeated attempts to make herself understood were unavailing, as she produced only inarticulate sounds. Sensation was normal, so far as I was able to elicit. The patellar reflex was very weak and alike on both sides. Headache was not present. No pain was felt in any part of the body. After the lapse of two days, she was able to extend, but not to flex, her leg. Motor power gradually returned, first in the leg and thigh, then in the hand and arm, lastly in the face and pharynx. In about six weeks the little patient was playing out-of-doors, apparently as well as before her illness.

A few days ago I went to see her, and was struck by her frail appearance. She has grown very little, if any. She is very thin. Her eyes are large and her pupils dilated. No areas of anesthesia were found. Her patellar reflexes on both sides were almost imperceptible. Her sister states that the child has always spoken slowly since her illness. Her grandfather states that she has never been the same since, but is weak in body and mind.

Jaborandi in Hiccough.

Nobel and Stiller (*Centralbl. f. Klin. Med.*, 1892, Nos. 32 and 42) respectfully refer to the good effects produced by jaborandi in hiccough. Nobel's patient was a man suffering from influenza, and the infusion of jaborandi was used. Nobel draws attention to the fact that, notwithstanding the presence of some cyanosis, the drug had no ill effect upon the heart. He refers to other recorded cases, and adds that it remains to be proved which constituent in jaborandi brings about the good results. Stiller says that he has long used pilocarpine (10 drops of a 1-per-cent. solution three or four times a day) in hiccough of nervous origin, and that it is the best remedy known for this condition. He does not employ it in the reflex hiccough of severe abdominal disease and peritonitis. At times, and especially in hysteria, only improvement or temporary cessation in the hiccough has been obtained, necessitating the further use of the drug. Stiller says that the good effects of jaborandi are due to pilocarpine.—*Med. Age.*

Gout in a Child Eleven Years Old.

Marboux (*Lyon Medical*, 1892, No. 43, p. 264) has reported the case of a girl, eleven years old, in which, after a brief period of malaise, sore-throat, and difficulty in swallowing, pain, redness and swelling appeared at the metatarso-phalangeal joint of the right great toe. On the following day, the symptoms subsided with the abruptness with which they had appeared, some discoloration,

pain, and swelling, however, persisting. A day later, the great toe of the left foot became similarly involved. Forty-five grains of sodium salicylate were administered in twenty-four hours, and decided improvement followed. There was no doubt from the mode of onset, from the appearance of the affected parts, and from the progress of the case, that the condition was gout. There was no family history of gout on either the father's or on the mother's side. The father had, however, eighteen months previously, had an attack of the same kind as the child. The child did not suffer from migraine or from gastric disorder or from cutaneous eruptions, nor had menstruation occurred.—*Med. News.*

Expectant Treatment in Typhoid Fever.

Dr. Arnot Spence details the results from this plan in three hundred and twenty-three cases of typhoid fever (*Med. Rec.*). Upon terminating his article he says: In conclusion we can say that of our cases nearly four per cent. died as the result of admission in a moribund state; that over three per cent. died of the accidents incidental to the intestinal lesions, as hemorrhages, perforation, and peritonitis; that 1.5 per cent. died of complicating pneumonia; that 6.8 per cent. died of the typhoid poison itself and its resulting exhaustion. That the death-rate was higher among the females than the males, and that the lowest mortality was in those cases of an age between fifteen and twenty years.

It is not likely that any treatment can be devised which will prevent absolutely such occurrences as intestinal hemorrhages and intestinal perforations, and therefore we shall have those to contend against. A treatment which may possibly antidote the specific poison of typhoid fever without lowering the vitality of the patient will be, in accordance with our present theory, the one to reduce its mortality.—*Wkly. Med. Rev.*

Treatment of Morphineism.

Obersteiner individualizes strictly in the treatment of the morphine habit. Beginning with the average daily dose, he withdraws it as rapidly as the patient can stand it. When the dose has been reduced to a few centigrammes, caution is necessary, as even a slight reduction is then badly borne. At this stage warm baths of from 5 to 15 minutes' duration, followed if necessary by the cold shower or cold pack for one-half hour to two hours at a temperature of 78° to 86° F., are often of benefit. Alcohol in liberal quantities often gives relief. Cocaine has no other use than to modify the symptoms, and should only be used when these become violent, say twenty-four to forty-eight hours after the last dose of morphine; it is always given by mouth in doses of 0.05 to 0.1 gramme, never exceeding 0.5 gramme per day, it should be reduced in a few days, and never continued longer than five or six days. Nutrition must

be improved by all possible means. If collapse occurs, morphine must be resorted to. Patients with cardiac troubles should not be subjected to complete withdrawal.—*Wien. Med. Presse.*

SURGERY.

Radical Cure of Femoral Hernia.

Salzer describes a new method of radical cure of a large femoral hernia. He objects to any attempt to bring together the margins of the ring by sutures, as the resistance of the fibrous structures would very probably cause local gangrene and sloughing. The plan of closing the canal by cicatricial tissue, either by removing its fatty and glandular contents, or by inserting foreign material, is also open to objection, as the new tissue thus produced is apt to become absorbed. His method consists in first removing the sac, and in the next place, in closing the external orifice by a flap formed by the fascia covering the pectineus muscle. This flap, the free convex margin of which is divided downwards, whilst its upper portion remains attached to the muscle, is turned upwards and fixed by sutures to the middle third of Poupart's ligament. In this way the septum crurale is replaced by a tough and resistant layer of fibrous tissue. The thickness of the pectineal fascia, it is stated, varies in different subjects, but the membrane is most likely to be found sufficiently resistant in old persons, and in those who have for a long time worn a truss for femoral hernia.—*Brit. Med. Jour.*

Significance of the Subjective Cerebral Symptoms in Middle-Ear Inflammation.

Dr. H. Knapp (*Archives of Otology*) says:

1. *Transient headache, nausea, vomiting, and dizziness*, in acute cases, indicate meningeal irritation. These cases almost all recover with or without mastotomy, only a few exceptional cases of fatal termination being on record.

2. *Persistent headache, nausea, vomiting, and dizziness* especially when the discharge from the ear diminishes, signify transition of meningeal irritation into real meningitis, and demand surgical interference—paracentesis of the drum membrane, especially the membrana flaccida when bulging, or opening of the mastoid after Schwartz or Kuster.

3. *The above symptoms with delirium, stupor, impediment of speech, chills, spasms, drowsiness, and coma* signify fully developed intracranial suppuration. In the majority of such cases it may be difficult or impossible to discriminate between thrombo-phlebitis, extradural and cerebral or cerebellar abscess. The special diagnosis and localization, when strengthened by valuable objective symptoms, such as painful swelling and hardness

of the internal jugular vein (sinus thrombosis), localized pain spontaneous or on percussion of the skull (abscess), a fistula in the cranial bones (extradural suppuration), may justify, even demand, surgical interference, namely, opening the posterior cranial fossa to ligate and cleanse the lateral sinus, or opening the posterior or middle fossa to liberate the extradural accumulation of pus, or opening the middle or posterior fossa to evacuate an encephalic abscess. Of all these varieties a certain, though small number of cases (seventeen) is known in which the diagnosis was correctly made and the operation successfully performed.—*Am. Lan.*

Clinical Classification of Hip-Disease.

In a consideration of coxitis Dr. Robert W. Lovett divides the trouble clinically (*Boston Med. and Surg. Jour.*) into four types. These four types are:

1. The Destructive Form, where the disease is rapid, severe, but little influenced by ordinary treatment; extensive infiltration of the soft parts takes place, and in most instances the disease passes on to a fatal issue.

2. The Painful Form, where pain is a prominent symptom, and exacerbations are common.

3. The Quiet or Painless Form, where pain is an unimportant factor or is entirely absent.

4. The Transient or Ephemeral Form, where the symptoms are mild and the course of the disease is run in a few months.

1. The Destructive Form—The type of hip-disease which he would place in this class occurs most often in children of tuberculous inheritance and poor vitality. Its onset is rapid and painful, often excessively painful. There is, almost from the first, much thickening of the trochanter and peri-articular tissues. The general condition is rapidly impaired, and abscess formation takes place early. One abscess follows another with profuse discharge through sinuses which open widely and are surrounded by colorless granulations. This type of disease most often begins as such, and is clearly a type by itself throughout. At other times, but rarely, it is superadded to one of the forms about to be described. The temperature is high, the wasting rapid, and a porky induration of the thigh ensues.—*Med. Rev.*

Treatment of Appendicitis.

1. All cases of catarrhal and ulcerative appendicitis should be treated by laparotomy and excision of the appendix as soon as the lesion can be recognized.

2. Excisions of the appendix in cases of simple, uncomplicated appendicitis is one of the easiest and safest of all intra-abdominal operation.

3. Excisions of the appendix in cases of appendicitis before perforation has occurred, is both a curative and prophylactic measure.

4. The most constant and reliable symptoms indicating the existence of appendicitis are recurring pains and circumscribed tenderness in the region of the appendix.

5. All operations should be done through a straight incision; parallel to and directly over the cæcum.

6. The stump after excision of the appendix should be carefully disinfected, iodoformized and covered with peritoneum by suturing the serous surface of the cæcum on each side over it with a number of Lambert stitches.

7. The abdominal incision should be closed by two rows of sutures, the first embracing the peritoneum, and the second the remaining structures of the margins of the wound.

8. Drainage in such cases is unnecessary and should be dispensed with.—*Med. Prog.*

NEWS AND MISCELLANY.

Salipyrin, the sale of which has been interdicted in the United States during the past year, because of conflicting proprietary interests, is now free for use in this country. (December, 1891.) *Notes on New Remedies* published a complete descriptive article on salipyrin. The product has been adopted in medical practice in Europe, and many clinical reports have resulted from trustworthy and authoritative sources. It is expected that physicians in this country will take up the remedy, and that the favorable results obtained by European physicians will be repeated here.

Dr. Mary Putnam Jacobi has been elected as president of the Neurological Section of the New York Academy of Medicine, at its last meeting to succeed Dr. Greame M. Hammond.

Mrs. Jacobi is the first female physician ever elected to the distinguished position of the presidency of a section, in the New York Academy since its foundation; now more than twenty-six years.

This is an honor deservedly bestowed on one who richly merits this unique and distinguished promotion; for though Mrs. Dr. Jacobi is no nerve specialist, her knowledge of diseases of the nervous system is deep and thorough.

It may be said, of this distinguished medical matron, that while progressive and aggressive as a writer, teacher and practitioner of the healing art, she yet preserves to a high degree, those feminine charms and graces so peculiar to the refined and cultured lady.

Dr. Thomas Lyon, the oldest and one of the most prominent physicians in Williamsport, died at his residence, December 25, 1892. His illness was of brief duration, only since

the 24th of last month, up to which time he gave earnest attention to his practice as a physician, although he was in the eightieth year of his age.

He was the father of six children, of whom four are living.

The following biography of the venerable physician appears in Meginess' Historical Journal issued in 1888:

"Dr. Thomas Lyon now takes rank as the oldest physician in active practice in Williamsport, Pa. He is a son of Edward Grundy Lyon and Sarah Lyon, of English birth, and was born October 13, 1812, near the borough of Muncy, Lycoming County, Pa. He received his education at the celebrated Milton academy, when the distinguished Rev. Dr. Kirkpatrick was the principal. He studied medicine under the famous Dr. James S. Dougal, of Milton, and graduated at the Jefferson Medical College, Philadelphia, 1838. When he located in Williamsport it had less than one thousand inhabitants, and he has followed his profession without interruption down to the present day. Dr. Lyon has made surgery a specialty, though his practice is general. He is a member of the Williamsport Medical Society, of the Lycoming County Medical Society, of the Pennsylvania State Medical Society and the American Medical Association. He has been president of the city and county associations and vice-president of the State Medical Society. During the war he was a member of the medical board of examiners for army surgeons. His contributions to medical literature have been published in the transactions of the State Medical Society. In 1843 he married Elizabeth R., daughter of Joseph R. Priestly, Esq., of Northumberland, and great-granddaughter of Dr. Joseph Priestly, the eminent chemist and discoverer of oxygen. Dr. Lyon, although in the fiftieth year of active practice, is still hale and vigorous, and gives promise of many more years of service."

ARMY AND NAVY.

FROM JANUARY 8, 1893, TO JANUARY 14, 1893.

The leave of absence granted First Lieutenant Samuel R. Dunlop, Assistant Surgeon, U. S. Army, is still further extended to include January 31, 1893.

The resignation of First Lieutenant Samuel R. Dunlop, Assistant Surgeon, U. S. Army, has been accepted by the President to take effect January 31, 1893.

The order directing Major Robert M. O'Reilly, Surgeon, U. S. Army, to proceed to Washington, D. C., and report for duty as Attending Surgeon, is suspended until further orders.

Lieutenant Col. Charles R. Greenleaf, Deputy Surgeon General, U. S. Army, is de-

talled as a delegate to the Eleventh International Medical Congress to convene at Rome, Italy, on the 24th of September, 1893, and will, at the proper time, proceed to the place designated. While abroad in pursuance of this order, he will visit such points in Great Britain, France, Germany, Russia, Austria, Italy, and elsewhere as may be deemed necessary by the Surgeon General of the Army, on official business, and on completion of the duty contemplated will return to his station in this city.

First Lieutenant J. D. Glennan, Assistant Surgeon, U. S. Army, having reported at Headquarters Department of Texas, will proceed to Carrizo, Texas, and report to the commanding officer of the Seventh Cavalry squadron at that place for duty.

Leave of absence for one month, with permission to apply for an extension of one month, is hereby granted Captain J. S. Powell, Assistant Surgeon, U. S. Army.

First Lieutenant B. S. Ten Eyck, Assistant Surgeon, U. S. Army, having reported for duty at Headquarters Department of Texas, will proceed to Laredo, Texas, for service in the field, to relieve Captain W. B. Davis, Assistant Surgeon, who, upon being thus relieved, will return to his station, Fort Sain, Houston, Texas.

First Lieutenant Frank R. Keefer, Assistant Surgeon, U. S. Army, is relieved from duty at Fort Riley, Kansas, and will report in person to the commanding officer, Fort Stanton, New Mexico, for duty at that post, relieving Captain John M. Banister, Assistant Surgeon.

Captain Banister, upon being relieved by First Lieutenant Keefer, will report in person to the commanding officer, Fort Leavenworth, Kansas, for duty at that post.

U. S. MARINE HOSPITAL SERVICE FOR THE FOUR WEEKS ENDING JANUARY 7, 1893.

Purviance, George, Surgeon, detailed as chairman of board for physical examination of Passed Assistant Surgeon, S. C. Devan, Dec. 21, 1892.

Gassaway, J. M. Surgeon, to proceed to Gulf Quarantine on special duty, Jan. 4, 1893.

Devan, S. C., Passed Assistant Surgeon, to report for physical examination, Dec. 21, 1892. Detailed for special duty at Philadelphia, Pa., Dec. 23, 1892. Granted leave of absence for two months on surgeon's certificate of disability, Jan. 7, 1893.

Kallock, P. C., Passed Assistant Surgeon, to assume command of the service at Cincinnati, Ohio, when relieved at Boston, Mass., Dec. 21, 1893.

Glennan, A. H., Passed Assistant Surgeon, leave of absence extended sixteen days on account of sickness, Dec. 13, 1892. To proceed to New York, N. Y., for special temporary duty, Jan. 3, 1893.

Williams, L. L., Passed Assistant Surgeon, to proceed to Helena, Arkansas, on special duty, Jan. 3, 1893.

McIntosh, W. P., Passed Assistant Surgeon. When relieved to proceed to Boston, Mass., for duty, Dec. 21, 1892.

Magruder, G. M., Passed Assistant Surgeon. When relieved to proceed to San Diego, Cal., on special duty, thence to New Orleans, La., for duty, Dec. 16, 1892.

Cobb, J. O., Passed Assistant Surgeon. When expiration of leave of absence to proceed to Port Townsend, Wash., for duty, Dec. 21, 1892.

Stimpson, W. G., Assistant Surgeon, to proceed to Detroit, Mich., for duty, Dec. 20, 1892.

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